



Facility Name & ID Number CAMBRIDGE NURSING & REHAB CENTER

# 0031385 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	41,245	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	41,245	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			3,359	3,359	8
9	SNF/PED					9
10	ICF	26,018	2,751	4,725	33,494	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,018	2,751	8,084	36,853	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.35%

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

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 03/23/88

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 03/23/88 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 16 and days of care provided 3,359

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number CAMBRIDGE NURSING & REHAB CENTI # 0031385 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

**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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	271,679	16,742	11,285	299,706		299,706	0	299,706		1
2	Food Purchase		146,846		146,846	0	146,846	0	146,846		2
3	Housekeeping	133,980	20,687	0	154,667		154,667	0	154,667		3
4	Laundry	78,594	23,175	0	101,769	0	101,769	0	101,769		4
5	Heat and Other Utilities			116,839	116,839		116,839	174	117,013		5
6	Maintenance	0	19,697	53,203	72,900		72,900	(5,070)	67,830		6
7	Other (specify):*			9,913	9,913		9,913	0	9,913		7
8	<b>TOTAL General Services</b>	484,253	227,147	191,240	902,640	0	902,640	(4,896)	897,744		8
	<b>B. Health Care and Programs</b>										
9	Medical Director	0		6,600	6,600		6,600	0	6,600		9
10	Nursing and Medical Records	1,759,683	44,065	78,360	1,882,108		1,882,108	0	1,882,108		10
10a	Therapy	24,096	757	1,760	26,613		26,613	0	26,613		10a
11	Activities	97,943	9,055	0	106,998		106,998	0	106,998		11
12	Social Services	109,636		6,772	116,408		116,408	0	116,408		12
13	CNA Training			0	0		0	0	0		13
14	Program Transportation			1,087	1,087		1,087	0	1,087		14
15	Other (specify):*				0		0	0	0		15
16	<b>TOTAL Health Care and Programs</b>	1,991,358	53,877	94,579	2,139,814	0	2,139,814	0	2,139,814		16
	<b>C. General Administration</b>										
17	Administrative	63,533		205,346	268,879		268,879	(50,311)	218,568		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			73,311	73,311		73,311	19,928	93,239		19
20	Dues, Fees, Subscriptions & Promotions			34,435	34,435		34,435	(22,384)	12,051		20
21	Clerical & General Office Expenses	107,627	9,561	249,084	366,272		366,272	(140,384)	225,888		21
22	Employee Benefits & Payroll Taxes			463,422	463,422	0	463,422	0	463,422		22
23	Inservice Training & Education			0	0		0	0	0		23
24	Travel and Seminar			8,665	8,665		8,665	(7,326)	1,339		24
25	Other Admin. Staff Transportation			9,543	9,543		9,543	0	9,543		25
26	Insurance-Prop.Liab.Malpractice			140,278	140,278		140,278	5,995	146,273		26
27	Other (specify):*			0	0		0	12,755	12,755		27
28	<b>TOTAL General Administration</b>	171,160	9,561	1,184,084	1,364,805	0	1,364,805	(181,727)	1,183,078		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,646,771	290,585	1,469,903	4,407,259	0	4,407,259	(186,623)	4,220,636		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
<b>1</b>	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	11,025
	REPAIRS & MAINTENANCE	260
		0
		11,285
<b>3</b>	<b>HOUSEKEEPING</b>	
		0
		0
		0
<b>4</b>	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
<b>5</b>	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	63,002
	ELECTRICITY	24,186
	WATER	24,303
	CABLE TV - LOBBY	5,348
		0
		116,839
<b>6</b>	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	18,136
	PAINTING & DECORATING	7,980
	BUILDING REPAIRS	2,346
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	12,983
	ELEVATOR MAINTENANCE & REPAIR	4,817
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	1,569
	FIRE SERVICE	5,372
		0
		0
		0
		0
		53,203
<b>7</b>	<b>OTHER</b>	
	SCAVENGER	9,913
	SECURITY SERVICE	0
		0
		0
		9,913
<b>9</b>	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	6,600
		6,600

LINE	SCHED REF	TOTAL
<b>10</b>	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	20,397
	PURCHASED SERVICES	28,111
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	4,576
	PHARMACY CONSULTANT XVIII B 39-2	1,276
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	24,000
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		78,360
<b>10a</b>	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	1,760
	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
		1,760
<b>11</b>	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
		0
<b>12</b>	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	6,772
		0
		6,772
<b>13</b>	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
<b>14</b>	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	1,087
<b>17</b>	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	205,346
	<b>DIRECTORS FEES</b>	
<b>18</b>	DIRECTORS FEES	0
<b>19</b>	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	18,815
	ADMINISTRATIVE CONSULTANTS XIX C	3,000
	PROFESSIONAL FEES XIX C	51,496
		0
		73,311
<b>20</b>	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	12,344
	EMPLOYEE WANT ADS XIX F	1,433
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	6,949
	LICENSES & PERMITS XIX F	3,669
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	8,097
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	1,943
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0
	PATIENT BACKGROUND CHECKS XIX F	0
		34,435
<b>21</b>	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	2,090
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	229,000
	PENALTIES / OVERDRAFT CHARGES VI 18	780
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	17,214
	MESSENGER SERVICE	0
		0
		249,084

LINE	SCHED REF	TOTAL
<b>22</b>	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	205,195
	UNEMPLOYMENT COMPENSATION XIX D	25,699
	WORKERS COMPENSATION INSURANC XIX D	37,958
	HOSPITALIZATION INSURANCE XIX D	165,050
	EMPLOYEE BENEFITS - OTHER XIX D	3,869
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	25,651
	CHICAGO HEAD TAX XIX D	0
		0
		463,422
<b>23</b>	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	0
		0
<b>24</b>	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	1,339
	TRAVEL XIX G	7,326
		8,665
<b>25</b>	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	9,543
		9,543
<b>26</b>	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	140,278
		140,278
<b>27</b>	<b>OTHER</b>	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

1,469,903

CAMBRIDGE NURSING & REHAB CENTER  
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)  
 12/31/2006

TOTAL FOOD PURCHASE	146,846	PATIENT MEALS	110559
LESS SALES TAX	0	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	146,846	TOTAL MEALS/YEAR	110559
TOTAL PATIENT CENSUS	36,853	NET FOOD	146846
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	110559
	-----		
TOTAL PATIENT MEALS	110559	COST PER MEAL	1.33
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY			-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		

Facility Name &amp; ID Number

CAMBRIDGE NURSING &amp; REHAB CENTER

#0031385

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			42,618	42,618		42,618	127,501	170,119			30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0			31
32	Interest			53,343	53,343		53,343	476,636	529,979			32
33	Real Estate Taxes			196,150	196,150		196,150	0	196,150			33
34	Rent-Facility & Grounds			528,748	528,748		528,748	(528,748)	0			34
35	Rent-Equipment & Vehicles			51,029	51,029		51,029	4,128	55,157			35
36	Other (specify):* Amort.comp.soft			4,254	4,254		4,254	0	4,254			36
37	<b>TOTAL Ownership</b>			876,142	876,142	0	876,142	79,517	955,659			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		256,610	439,082	695,692		695,692	0	695,692			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			62,207	62,207		62,207	0	62,207			42
43	Other (specify):*				0		0	0	0			43
44	<b>TOTAL Special Cost Centers</b>	0	256,610	501,289	757,899	0	757,899	0	757,899			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	2,646,771	547,195	2,847,334	6,041,300	0	6,041,300	(107,106)	5,934,194			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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>OHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(31,508)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(780)	21		18
19	Entertainment	0	20		19
20	Contributions	(1,943)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	0	27		24
25	Fund Raising, Advertising and Promotional	(12,344)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(8,097)	20		28
29	Other-Attach Schedule	(243,486)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (298,158)</b>		<b>\$ 0</b>	<b>30</b>

<b>BHF USE ONLY</b>					
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	2	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	191,052		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ 191,052</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (107,106)</b>		<b>37</b>

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

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

		1	2	3	4
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
38	Medically Necessary Transport.		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	Exceptional Care Program		X		44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>	<b>47</b>

STATE OF ILLINOIS  
CAMBRIDGE NURSING & REHAB CENTER

ID# 0031385

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ (5,070)	6	1
2	BANK CHARGES	(2,090)	21	2
3	OUTSIDE CLERICAL	(205,000)	21	3
4	OUTSIDE SERVICES	(24,000)	21	4
5	NON ALLOWABLE TRAVEL	(7,326)	24	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	<b>Total</b>	(243,486)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number CAMBRIDGE NURSING & REHAB CENTER# 0031385

Report Period Beginning:

01/01/2006

Ending:

12/31/2006**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	0	0	0	0	0	0	0	0	0	0	0	0	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	174	0	0	0	0	0	0	0	0	0	174	5
6	Maintenance	(5,070)	0	0	0	0	0	0	0	0	0	0	(5,070)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(5,070)</b>	<b>174</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(4,896)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(50,311)	0	0	0	0	0	0	0	0	0	(50,311)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	19,928	0	0	0	0	0	0	0	0	0	19,928	19
20	Fees, Subscriptions & Promotions	(22,384)	0	0	0	0	0	0	0	0	0	0	(22,384)	20
21	Clerical & General Office Expenses	(231,870)	91,486	0	0	0	0	0	0	0	0	0	(140,384)	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	(7,326)	0	0	0	0	0	0	0	0	0	0	(7,326)	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	1,060	4,935	0	0	0	0	0	0	0	0	5,995	26
27	Other (specify):*	0	12,755	0	0	0	0	0	0	0	0	0	12,755	27
28	<b>TOTAL General Administration</b>	<b>(261,580)</b>	<b>74,918</b>	<b>4,935</b>	<b>0</b>	<b>(181,727)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(266,650)</b>	<b>75,092</b>	<b>4,935</b>	<b>0</b>	<b>(186,623)</b>	<b>29</b>							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CAMBRIDGE NURSING & REHAB CENTER # 0031385 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(31,508)	0	159,009	0	0	0	0	0	0	0	0	127,501	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	476,636	0	0	0	0	0	0	0	0	476,636	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(528,748)	0	0	0	0	0	0	0	0	(528,748)	34
35	Rent-Equipment & Vehicles	0	4,128	0	0	0	0	0	0	0	0	0	4,128	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(31,508)</b>	<b>4,128</b>	<b>106,897</b>	<b>0</b>	<b>79,517</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(298,158)</b>	<b>79,220</b>	<b>111,832</b>	<b>0</b>	<b>(107,106)</b>	<b>45</b>							

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
JACOB GRAFF	100	SKOKIE MEADOWS 2	SKOKIE	PREMIER		BOOKKEEPING
		MOMENCE MEADOWS		MANAGEMENT	SKOKIE	MANAGEMENT

**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	17 MANAGEMENT FEES	\$ 205,346	PREMIER MANAGEMENT		\$	(205,346)	1	
2	V	5 UTILITIES				174	174	2	
3	V	17 OFFICER SALARIES				72,579	72,579	3	
4	V	17 ADMINISTRATIVE SALARIES				49,503	49,503	4	
5	V	17 ADMINISTRATIVE SALARIES				32,953	32,953	5	
6	V	19 PROFESSIONAL FEES				19,928	19,928	6	
7	V	21 CLERICAL SALARIES				45,939	45,939	7	
8	V	21 CLERICAL SALARIES				16,046	16,046	8	
9	V	21 CLERICAL SALARIES				14,497	14,497	9	
10	V	21 OFFICE EXPENSE				15,004	15,004	10	
11	V	26 INSURANCE				1,060	1,060	11	
12	V	27 PAYR.TAXES/HEALTH INS				12,755	12,755	12	
13	V	35 OFFICE RENTAL				4,128	4,128	13	
14	Total		\$ 205,346			\$ 284,566	\$ *	79,220	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	34 RENT	\$ 528,748	M O SKOKIE MEADOWS		\$	(528,748)
16	V	26 INSURANCE				4,935	4,935
17	V	30 DEPRECIATION				159,009	159,009
18	V	32 INTEREST				476,636	476,636
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 528,748			\$ 640,580	\$ * 111,832

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

Facility Name & ID Number CAMBRIDGE NURSING & REHAB CENT # 0031385 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

## 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	JACOB GRAFF	PRESIDENT	ADMINISTRATIV	100.00	SEE ATTACHED	SEE ATTACHED		SALARY	\$ 72,579	17-7	1
2			BANKING								2
3			FINANCING								3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 72,579		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 CENTER

# 0031385

Report Period Beginning:

01/01/2006

Ending: 2/31/2006

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization PREMIER MANAGEMENT  
 Street Address 9933 N. LAWLER  
 City / State / Zip Code SKOKIE, IL 60077  
 Phone Number ( 847 ) 679-7733  
 Fax Number ( 847 ) 679-7736

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	5	UTILITIES	PER RESIDENT DAY	253,882	8	\$ 1,200	\$ 36,853	\$ 174	1	
2	17	OFFICER SALARIES	PER RESIDENT DAY	253,882	8	500,000	500,000	36,853	72,579	2
3	17	ADMINISTRATIVE SALARIES	DIRECT	10	3	123,758	123,758	4	49,503	3
4	17	ADMINISTRATIVE SALARIES	PER RESIDENT DAY	253,882	8	227,013	227,013	36,853	32,953	4
5	19	PROFESSIONAL FEES	PER RESIDENT DAY	253,882	8	137,283		36,853	19,928	5
6	21	CLERICAL SALARIES	DIRECT	10	3	114,848	114,848	4	45,939	6
7	21	CLERICAL SALARIES	DIRECT	10	4	53,487	53,487	3	16,046	7
8	21	CLERICAL SALARIES	PER RESIDENT DAY	253,882	8	99,870	99,870	36,853	14,497	8
9	21	OFFICE EXPENSE	PER RESIDENT DAY	253,882	8	103,364		36,853	15,004	9
10	26	INSURANCE	PER RESIDENT DAY	253,882	8	7,300		36,853	1,060	10
11	27	PAYR.TAXES/HEALTH INS	PER RESIDENT DAY	253,882	8	87,868		36,853	12,755	11
12	35	OFFICE RENTAL	PER RESIDENT DAY	253,882	8	28,435		36,853	4,128	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					\$ 1,484,426	\$ 1,118,976	\$ 284,566		25

Facility Name & ID Number CAMBRIDGE NURSING & REHAB CENTER

# 0031385

Report Period Beginning:

01/01/2006

Ending: 2/31/2006

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 M O SKOKIE MEADOWS NURSING  
 Street Address 9615 N KNOX  
 City / State / Zip Code SKOKIE,IL 60076  
 Phone Number ( 847 )679-7733  
 Fax Number ( 847 )679-7734

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	26	INSURANCE	DIRECT	1	1	\$ 4,935	\$ 1	\$ 4,935	1
2	30	DEPRECIATION	DIRECT	1	1	159,009	1	159,009	2
3	32	INTEREST	DIRECT	1	1	476,636	1	476,636	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					\$ 640,580	\$	\$ 640,580	25

Facility Name & ID Number CAMBRIDGE NURSING & REHAB CENTI

# 0031385

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	CAMBRIDGE		X	MORTGAGE	\$44,062.00	8/16/01	\$ 6,822,050	\$ 6,540,676	8/16/36	0.0710	\$ 466,089	1						
2	CAMBRIDGE		X	MORTGAGE	\$5,008.00	9/30/06	835,500	789,005		0.0590	10,547	2						
3												3						
4												4						
5												5						
<b>Working Capital</b>																		
6	IST EQUITY		X	WORKING CAPITAL	INT ONLY			524,852			53,343	6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>				\$49,070.00		\$ 7,657,550	\$ 7,854,533			\$ 529,979	9						
<b>B. Non-Facility Related*</b>																		
10	IRS, IDR, ETC		X	LATE FEES								10						
11												11						
12												12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$ 0	\$ 0			\$ 0	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 7,657,550	\$ 7,854,533			\$ 529,979	15						

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

\* 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**

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2005 report.

\$ **242,260** 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.)

\$ **219,205** 2

3. Under or (over) accrual (line 2 minus line 1).

\$ **(23,055)** 3

4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)

\$ **219,205** 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.

\$ **196,150** 7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	<b>156,179</b>	8
	2002	<b>159,393</b>	9
	2003	<b>201,402</b>	10
	2004	<b>242,261</b>	11
	2005	<b>219,205</b>	12

<b>FOR BHF USE ONLY</b>		
13	FROM R. E. TAX STATEMENT FOR 2005	\$ 13
14	PLUS APPEAL COST FROM LINE 5	\$ 14
15	LESS REFUND FROM LINE 6	\$ 15
16	AMOUNT TO USE FOR RATE CALCULATION	\$ 16

**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 2005 TAX BILL.**

**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.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2005 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME CAMBRIDGE NURSING & REHAB CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0031385

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 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>10-10-304-007-0000</u>	<u>NURSING HOME</u>	\$ <u>36,530.84</u>	\$ <u>36,530.84</u>
2. <u>10-10-304-008-0000</u>	<u>NURSING HOME</u>	\$ <u>36,534.88</u>	\$ <u>36,534.88</u>
3. <u>10-10-304-009-0000</u>	<u>NURSING HOME</u>	\$ <u>36,534.88</u>	\$ <u>36,534.88</u>
4. <u>10-10-304-010-0000</u>	<u>NURSING HOME</u>	\$ <u>36,534.88</u>	\$ <u>36,534.88</u>
5. <u>10-10-304-011-0000</u>	<u>NURSING HOME</u>	\$ <u>36,534.88</u>	\$ <u>36,534.88</u>
6. <u>10-10-304-012-0000</u>	<u>NURSING HOME</u>	\$ <u>36,534.88</u>	\$ <u>36,534.88</u>
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>219,205.24</u>	\$ <u>219,205.24</u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

**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.



Facility Name &amp; ID Number CAMBRIDGE NURSING &amp; REHAB CENTER

# 0031385

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	113	1990		\$ 1,968,925	\$ 62,506	31.5	\$ 62,506	\$	\$ 961,048	4
5										5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	IMPROVEMENT		1987	4,888	155	20	155		4,147	9
10	IMPROVEMENT		1988	3,196	101	31.5	101		1,893	10
11	IMPROVEMENT		1990	29,530	937	31.5	937		15,044	11
12	IMPROVEMENT		1991	20,962	665	31.5	665		10,337	12
13	IMPROVEMENT		1992	18,635	593	31.5	593		8,552	13
14	IMPROVEMENT		1993	50,200	1,594	31.5	1,594		22,109	14
15	IMPROVEMENT		1993	8,052	206	39	206		2,755	15
16	IMPROVEMENT		1994	71,864	1,843	39	1,843		23,153	16
17	FIRE DAMPERS		1995	4,980	128	39	128		1,520	17
18	NURSE STATION REMODELING		1995	70,129	1,798	39	1,798		20,603	18
19	CONCRETE WORK, PATIO, RAMPS		1995	21,904	1,460	39	1,460		16,973	19
20	RESIDENT ROOM REMODELING		1996	25,459	653	15	653		6,938	20
21	ROOF		1996	1,200	31	39	31		341	21
22	REHABBING 1ST FLOOR CORRIDOR LOWER WALLS		1997	14,497	372	39	372		3,550	22
23	DOOR		1997	1,455	37	39	37		368	23
24	ELEVATOR RENOVATION		1997	14,791	379	39	379		3,458	24
25	FIRE DAMPERS		1998	7,282	187	39	187		1,659	25
26	EXHAUST FANS		1998	4,135	106	39	106		917	26
27	FIRE DAMPERS & 21 GRILLS		1998	22,408	575	39	575		4,956	27
28	ACCESS PANELS & FIRE DAMPERS		1998	2,720	70	39	70		569	28
29	TILING		1999	14,344	368	39	368		2,775	29
30	KIL-BAR		1999	3,587	92	39	92		694	30
31	WALL HEATERS		1999	6,392	164	39	164		1,237	31
32	DOOR		1999	1,190	30	39	30		227	32
33	WINDOW REPLACEMENT		1999	61,410	1,575	39	1,575		11,878	33
34	SHOWER ROOM TILING		1999	9,206	236	39	236		1,780	34
35	GENERATOR		2000	62,880	2,287	27.5	2,287		14,865	35
36	TILING		2000	6,052	220	27.5	220		1,430	36

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

See Page 12A, Line 70 for total

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

Facility Name &amp; ID Number CAMBRIDGE NURSING &amp; REHAB CENTER

# 0031385

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	WALL COVERING	2000	\$ 33,819	\$ 3,020	7	\$ 3,538	\$ 518	\$ 33,819	37
38	AWNING	2001	2,951	107	27.5	107		593	38
39	CORNICES	2001	1,741	63	27.5	63		349	39
40	ROOF	2001	50,988	1,854	27.5	1,854		10,274	40
41	DOOR	2001	2,160	79	27.5	79		438	41
42	ELEVATOR DOOR	2001	10,450	380	27.5	380		2,106	42
43	TWO DECK ROOFS	2001	12,100	440	27.5	440		2,438	43
44	5 TON CONDENSING UNIT	2001	2,854	104	27.5	104		576	44
45	WALLPAPERING, PAINTING	2002	60,000	4,838	5	12,000	7,162	54,000	45
46	FLORIDA SMOKING ROOM	2002	27,967	1,017	27.5	1,017		4,619	46
47	DUCTLESS SPLIT ROOM	2002	12,377	450	27.5	450		2,044	47
48	VALVE	2002	2,160	78	27.5	78		355	48
49	SIGN	2002	2,450	163	15	163		734	49
50	SHEET LEAD SHOWER LINER PANS	2002	5,471	199	27.5	199		904	50
51	SHOWER BASIN TILING	2002	15,498	564	27.5	564		2,561	51
52	PAVING PARKING LOT	2002	12,495	833	15	833		3,748	52
53	CONCRETE FOOTINGS, WALLS, STEPS,	2002	29,975	1,090	27.5	1,090		4,950	53
54	COOLER DOOR	2002	3,772	137	27.5	137		622	54
55	SIGN	2002	4,590	306	15	306		1,377	55
56	TUCKPOINTING	2002	24,600	894	27.5	894		4,061	56
57	4 TON CONDENSING UNIT	2002	4,800	175	27.5	175		794	57
58	VCT, COVE BASE	2003	4,639	168	27.5	168		595	58
59	ELEVATOR SAFETY EDGE	2003	1,575	58	27.5	58		205	59
60	NURSE CALL SYSTEM	2003	4,596	167	27.5	167		592	60
61	CARPET	2003	1,752	141	5	154	13	812	61
62	BLINDS	2003	2,648	153	5	530	377	2,120	62
63	CUBICLE CURTAINS, PAINTING, WALLPAPER	2003	5,805	334	5	1,161	827	4,644	63
64	INSTALL TRENCH DRAIN	2004	8,120	694	15	771	77	1,948	64
65	LIGHT FIXTURES	2004	9,188	334	27.5	334		849	65
66	REHAB ELEVATOR	2004	29,846	1,085	27.5	1,085		2,758	66
67	10 TON COOLING UNITS	2004	16,983	618	27.5	618		1,570	67
68	TILING, COVE BASE	2004	64,000	2,327	27.5	2,327		4,751	68
69	CEILINGS & LIGHTING	2004	51,173	1,861	27.5	1,861		3,800	69
70	TOTAL (lines 4 thru 69)		\$ 3,055,816	\$ 104,099		\$ 113,073	\$ 8,974	\$ 1,301,782	70

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,055,816	\$ 104,099		\$ 113,073	\$ 8,974	\$ 1,301,782	1
2	WATER HEATER	2005	4,650	169	27.5	169		247	2
3	DRYWALL	2005	3,725	136	27.5	136		198	3
4	WALK IN COOLER CONDENSING UNIT	2005	7,343	267	27.5	267		389	4
5	RESURFACING FRONT WALLS	2005	12,800	1,216	15	640	(576)	1,280	5
6	TELEPHONE WIRING	2006	6,243	66	27.5	66		66	6
7	EXHAUST FAN	2006	13,668	145	27.5	146	1	146	7
8	COMPRESSOR	2006	4,763	50	27.5	50		50	8
9	HEATING & A/C UNIT	2006	39,000	414	27.5	414		414	9
10	ELECTRICAL WORK	2006	2,980	32	27.5	32		32	10
11	BATHROOM REMODELING	2006	16,500	175	27.5	175		175	11
12	SIGN	2006	3,500	175	15	233	58	233	12
13	CANOPY	2006	1,424	71	15	95	24	95	13
14	hud remodeling proj.-painting, carpentry,flooring,architect	2006	487,844	5,174	27.5	5,174		5,174	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)		\$ 3,660,256	\$ 112,189		\$ 120,670	\$ 8,481	\$ 1,310,281	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 323,564	\$ 13,778	\$ 30,534	\$ 16,756		\$ 244,171	71
72	Current Year Purchases	378,296	75,660	18,915	(56,745)		18,915	72
73	Fully Depreciated Assets	477,741			0		477,741	73
74					0			74
75	TOTALS	\$ 1,179,601	\$ 89,438	\$ 49,449	\$ (39,989)		\$ 740,827	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$ 0		\$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 0	\$ 0	\$ 0	\$ 0		\$ 0	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,187,432	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 201,627	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 170,119	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (31,508)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,051,108	85

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

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

G. Construction-in-Progress

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

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

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

**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:			\$ 528,748			3
4	Additions						4
5							5
6							6
7	<b>TOTAL</b>			\$ 528,748			7

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

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?  YES  NO

16. Rental Amount for movable equipment: \$ 38,139 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	FACILITY VAN	2002 ECOCO VAN	\$ 555.00	\$ 6,702	17
18	ADMINISTRATOR	2006 CAD CTS	449.00	5,388	18
19				800	19
20					20
21	<b>TOTAL</b>		\$ #####	\$ 12,890	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_ /2007 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2008 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2009 \$ \_\_\_\_\_

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
<p><b>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</b></p>		

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	<b>TOTALS</b>	\$ 0	\$ 0	\$ 0	\$ 0
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$ 0			

**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)	
<b>TOTAL TRAINED</b>	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 178,196	\$		\$ 178,196	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			19,359			19,359	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			195,707			195,707	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 prescripts				256,610		256,610	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					45,820			45,820	13
14	<b>TOTAL</b>			\$		\$ 439,082	\$ 256,610		\$ 695,692	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.

Facility Name &amp; ID Number CAMBRIDGE NURSING &amp; REHAB CENTER

# 0031385

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 2,159,915	\$	1
2	Cash-Patient Deposits	3,457		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,528,964		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	64,988		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 3,757,324	\$ 0	10
	<b>B. Long-Term Assets</b>			
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	536,115		15
16	Equipment, at Historical Cost	206,366		16
17	Accumulated Depreciation (book methods)	(225,147)		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 (spec <u>Construction Progress</u> ):	100,000		22
23	Other(specify): <u>Due From Related Parties</u>	8,255,787		23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 8,873,121	\$ 0	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 12,630,445	\$ 0	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 182,302	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,944,032		29
30	Accrued Salaries Payable	157,605		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	219,205		32
33	Accrued Interest Payable	2,975		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 2,506,119	\$ 0	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	32,102		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 32,102	\$ 0	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 2,538,221	\$ 0	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 10,092,224	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 12,630,445	\$ 0	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>6,338,833</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>skokie 2 eliminations entry &amp; post closing entry</b>	<b>4,142,055</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>10,480,888</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(388,664)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(388,664)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ <b>0</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>10,092,224</b>	<b>24</b> *

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

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

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

1

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 5,293,216	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,293,216	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	358,068	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 358,068	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 0	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	34	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 34	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>VENDING COMMISSIONS</b>	1,318	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,318	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,652,636	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	902,640	31
32	Health Care	2,139,814	32
33	General Administration	1,364,805	33
	<b>B. Capital Expense</b>		
34	Ownership	876,142	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	695,692	35
36	Provider Participation Fee	62,207	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,041,300	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(388,664)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (388,664)	43

\* 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.

TAX RETURN NOT COMPLETED AT TIME OF COST REPORT FILING

\*\*\* 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 CENTER

# 0031385

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

**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	7,776	8,472	\$ 264,723	\$ 31.25	1
2	Assistant Director of Nursing					2
3	Registered Nurses	27,859	30,774	839,305	27.27	3
4	Licensed Practical Nurses	1,482	1,538	40,416	26.28	4
5	CNAs & Orderlies	55,092	58,785	615,239	10.47	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,822	1,954	24,096	12.33	8
9	Activity Director					9
10	Activity Assistants	8,301	9,056	97,943	10.82	10
11	Social Service Workers	5,640	6,128	109,636	17.89	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,845	23,318	271,679	11.65	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	13,081	14,308	133,980	9.36	18
19	Laundry	7,221	8,206	78,594	9.58	19
20	Administrator	1,992	2,080	63,533	30.54	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,068	8,848	107,627	12.16	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(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	159,179	173,467	\$ 2,646,771 *	\$ 15.26	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	M	\$ 11,025	1-3	35
36	Medical Director	O	6,600	9-3	36
37	Medical Records Consultant	N	4,576	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	1,276	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	6,772	12-3	45
46	Other(specify) <u>REHABILITATION</u>	S	1,760	12-3	46
47	<u>PSYCHIATRIC</u>		24,000	10-3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 56,009		49

**C. CONTRACT NURSES**

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

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
<b>RUDULPH STERNSCHGN</b>	<b>ADMINISTRATOR</b>		\$ <b>63,533</b>	Workers' Compensation Insurance	\$ <b>37,958</b>	IDPH License Fee	\$	
			<b>0</b>	Unemployment Compensation Insurance	<b>25,699</b>	Advertising: Employee Recruitment	<b>1,433</b>	
				FICA Taxes	<b>205,195</b>	Health Care Worker Background Check	<b>0</b>	
				Employee Health Insurance	<b>165,050</b>	(Indicate # of checks performed _____)		
				Employee Meals	<b>0</b>	<b>Patient Background Checks</b>	<b>0</b>	
				Illinois Municipal Retirement Fund (IMRF)*		<b>TRUST/FRANCHISE/CONTRIB/ETC</b>	<b>1,943</b>	
				<b>EMPLOYEE BENEFITS - OTHER</b>	<b>3,869</b>	<b>MARKETING/ADV/PROMO</b>	<b>20,441</b>	
				<b>EMPLOYEE PHYSICAL EXAMS</b>	<b>0</b>	<b>LICENSES/DUES/SUBSCRIPTIONS</b>	<b>10,618</b>	
				<b>PENSION/PROFIT SHARING PLANS</b>	<b>25,651</b>	<b>MGMT CO ALLOC</b>		
<b>TOTAL (agree to Schedule V, line 17, col. 1)</b>			\$ <b>63,533</b>	<b>CHICAGO HEAD TAX</b>	<b>0</b>	<b>TRUST/FRANCHISE/CONTRIB/ETC</b>	<b>(1,943)</b>	
<b>(List each licensed administrator separately.)</b>				<b>INSURANCE - EXECUTIVE LIFE</b>	<b>0</b>	<b>Less: Public Relations Expense</b>	<b>( 0 )</b>	
						<b>Non-allowable advertising</b>	<b>(12,344)</b>	
						<b>Yellow page advertising</b>	<b>(8,097)</b>	
						<b>TOTAL (agree to Sch. V, line 20, col. 8)</b>	\$ <b>12,051</b>	
				<b>INSURANCE - EXECUTIVE LIFE VI 21</b>	<b>0</b>			
				<b>TOTAL (agree to Schedule V, line 22, col.8)</b>	\$ <b>463,422</b>			
<b>TOTAL (agree to Schedule V, line 17, col. 3)</b>			\$ <b>205,346</b>	<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>			<b>G. Schedule of Travel and Seminar**</b>	
<b>(Attach a copy of any management service agreement)</b>				Description	Line #	Amount	Description	Amount
						\$	Out-of-State Travel	\$
							In-State Travel	
								<b>7,326</b>
							<b>NON ALLOWABLE TRAVEL</b>	<b>(7,326)</b>
							Seminar Expense	
								<b>1,339</b>
							Entertainment Expense	( )
<b>SEE SCHEDULE ATTACHED</b>			<b>73,311</b>				(agree to Sch. V, line 24, col. 8)	
<b>TOTAL (agree to Schedule V, line 19, column 3)</b>			\$ <b>73,311</b>	<b>TOTAL</b>		\$	<b>TOTAL</b>	\$ <b>1,339</b>
<b>(If total legal fees exceed \$5,000, attach copy of invoices.)</b>								

\* Attach copy of IMRF notifications

\*\*See instructions.

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

1	2	3	4	5	6	7	8	9	10	11	12	13													
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
																	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1	PAINT/DECORATING	2001	\$ 4,429	3 YRS	\$ 1,477	\$ 736																			
2	PAINT/DECORATING	2002	642	3 YRS	214	214	107																		
3	PAINT/DECORATING	2005	1,501	3 YRS				250	500	500	251														
4	PAINT/DECORATING	2006	7,980	3 YRS				2,660	1,330	1,330	2,660														
5																									
6																									
7																									
8																									
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16																									
17																									
18																									
19																									
20	<b>TOTALS</b>		\$ 14,552		\$ 1,691	\$ 950	\$ 107	\$ 2,910	\$ 1,830	\$ 1,830	\$ 2,911	\$													

**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 LONG TERM CARE \$5818
- (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. \$ 62,207  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 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: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES  
Attach invoices and a summary of services for all architect and appraisal fees