



Facility Name & ID Number CAMBRIDGE NURSING REHAB CENTER# 0048959 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

## III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>113</u>	Skilled (SNF)	<u>113</u>	<u>41,245</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>113</u>	TOTALS	<u>113</u>	<u>41,245</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF			<u>4,070</u>	<u>4,070</u>	8
9	SNF/PED					9
10	ICF	<u>26,002</u>	<u>2,726</u>	<u>3,533</u>	<u>32,261</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>26,002</u>	<u>2,726</u>	<u>7,603</u>	<u>36,331</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.09%

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)

NONEF. Does the facility maintain a daily midnight census? YES

G. Do pages 3 &amp; 4 include expenses for services or investments not directly related to patient care?

YES  NO 

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

YES  NO 

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

Date started 11/01/07

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

YES  Date 11/01/07 NO 

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

YES  NO  If YES, enter number of beds certified 113 and days of care provided 4,070Medicare Intermediary NGS

## IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\* Is your fiscal year identical to your tax year? YES  NO Tax Year: 12/31/2009 Fiscal Year: 12/31/09

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

Facility Name & ID Number CAMBRIDGE NURSING REHAB CENTER # 0048959 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	304,474	10,648	11,970	327,092		327,092		327,092		1
2	Food Purchase		173,985		173,985		173,985	(138)	173,847		2
3	Housekeeping	107,307	17,577		124,884		124,884		124,884		3
4	Laundry	185,659	25,806		211,465		211,465		211,465		4
5	Heat and Other Utilities			121,514	121,514		121,514		121,514		5
6	Maintenance	32,430	17,670	56,867	106,967		106,967		106,967		6
7	Other (specify):*			9,783	9,783		9,783		9,783		7
8	<b>TOTAL General Services</b>	629,870	245,686	200,134	1,075,690		1,075,690	(138)	1,075,552		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	1,691,232	70,266	56,354	1,817,852		1,817,852		1,817,852		10
10a	Therapy										10a
11	Activities	90,601	8,260	1,824	100,685		100,685		100,685		11
12	Social Services	111,330		3,528	114,858		114,858		114,858		12
13	CNA Training										13
14	Program Transportation			4,235	4,235		4,235		4,235		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,893,163	78,526	77,941	2,049,630		2,049,630		2,049,630		16
	<b>C. General Administration</b>										
17	Administrative	17,464		312,000	329,464		329,464		329,464		17
18	Directors Fees										18
19	Professional Services			92,274	92,274		92,274		92,274		19
20	Dues, Fees, Subscriptions & Promotions			65,485	65,485		65,485	(45,795)	19,690		20
21	Clerical & General Office Expenses	174,645	9,932	6,471	191,048		191,048	(180)	190,868		21
22	Employee Benefits & Payroll Taxes			517,684	517,684		517,684		517,684		22
23	Inservice Training & Education										23
24	Travel and Seminar			480	480		480		480		24
25	Other Admin. Staff Transportation			4,900	4,900		4,900		4,900		25
26	Insurance-Prop.Liab.Malpractice			149,344	149,344		149,344	10,736	160,080		26
27	Other (specify):*			125,500	125,500		125,500	(125,500)			27
28	<b>TOTAL General Administration</b>	192,109	9,932	1,274,138	1,476,179		1,476,179	(160,739)	1,315,440		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,715,142	334,144	1,552,213	4,601,499		4,601,499	(160,877)	4,440,622		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	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	11,970
	REPAIRS & MAINTENANCE	0
		0
		11,970
3	<b>HOUSEKEEPING</b>	
		0
		0
		0
4	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	62,112
	ELECTRICITY	34,083
	WATER	19,115
	CABLE TV - LOBBY	6,204
		0
		121,514
6	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	600
	PAINTING & DECORATING	13,139
	BUILDING REPAIRS	7,245
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	14,463
	ELEVATOR MAINTENANCE & REPAIR	5,640
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	3,111
	FIRE SERVICE	2,174
	CONTRACTED BUILDING MAIN	10,495
		0
		0
		0
		56,867
7	<b>OTHER</b>	
	SCAVENGER	9,783
	SECURITY SERVICE	0
		0
		0
		9,783
9	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	12,000
		12,000

LINE	SCHED REF	TOTAL
10	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	10,970
	PURCHASED SERVICES	27,218
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	4,320
	PHARMACY CONSULTANT XVIII B 39-2	1,766
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	12,000
	PSYCHIATRIC XVIII B __-2	80
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		56,354
10a	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	
	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	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	1,824
		0
		1,824
12	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	3,528
		0
		3,528
13	<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
14	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	4,235
		0
17	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	312,000
	<b>DIRECTORS FEES</b>	
18	DIRECTORS FEES	0
19	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	4,326
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	87,948
		0
		92,274
20	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	41,605
	EMPLOYEE WANT ADS XIX F	239
	CONTRIBUTIONS VI 20 XIX F	1,000
	DUES & SUBSCRIPTIONS XIX F	16,802
	LICENSES & PERMITS XIX F	2,649
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	3,190
	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
		65,485
21	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	180
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	0
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	6,264
	MESSENGER SERVICE	27
		0
		6,471

LINE	SCHED REF	TOTAL
22	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	213,136
	UNEMPLOYMENT COMPENSATION XIX D	19,653
	WORKERS COMPENSATION INSURANC XIX D	91,771
	HOSPITALIZATION INSURANCE XIX D	161,343
	EMPLOYEE BENEFITS - OTHER XIX D	6,119
	EMPLOYEE PHYSICAL EXAMS XIX D	1,150
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	24,512
	CHICAGO HEAD TAX XIX D	0
		0
		517,684
23	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	0
		0
24	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	480
	TRAVEL XIX G	0
		480
25	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	4,900
		4,900
26	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	149,344
		149,344
27	<b>OTHER</b>	
	BAD DEBTS VI 24	125,500
		125,500

GRAND TOTAL COLUMN 3 OTHER

**1,552,213**

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			38,611	38,611		38,611	108,933	147,544			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			18,739	18,739		18,739	464,822	483,561			32
33	Real Estate Taxes			235,079	235,079		235,079		235,079			33
34	Rent-Facility & Grounds			513,215	513,215		513,215	(513,215)				34
35	Rent-Equipment & Vehicles			50,061	50,061		50,061		50,061			35
36	Other (specify):*							37,879	37,879			36
37	<b>TOTAL Ownership</b>			855,705	855,705		855,705	98,419	954,124			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		236,750	408,193	644,943		644,943		644,943			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			61,868	61,868		61,868		61,868			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		236,750	470,061	706,811		706,811		706,811			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,715,142	570,894	2,877,979	6,164,015		6,164,015	(62,458)	6,101,557			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>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(30,031)	30		9
10	Interest and Other Investment Income	(8,323)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(138)	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		21		18
19	Entertainment		20		19
20	Contributions	(1,000)	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	(125,500)	27		24
25	Fund Raising, Advertising and Promotional	(41,605)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(3,190)	20		28
29	Other-Attach Schedule	(180)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (209,967)		\$	30

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

		1	2	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	147,509		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 147,509		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (62,458)		37

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

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

		1	2	3	4
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
38	Medically Necessary Transport.		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

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

STATE OF ILLINOIS  
CAMBRIDGE NURSING REHAB CENTER

ID# 0048959

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 0	6	1
2	BANK CHARGE	(180)	21	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	<b>Total</b>	(180)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number CAMBRIDGE NURSING REHAB CENTER# 0048959

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

## 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	(138)	0	0	0	0	0	0	0	0	0	0	(138)	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	<b>TOTAL General Services</b>	<b>(138)</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>(138)</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	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	(45,795)	0	0	0	0	0	0	0	0	0	0	(45,795)	20
21	Clerical & General Office Expenses	(180)	0	0	0	0	0	0	0	0	0	0	(180)	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	10,736	0	0	0	0	0	0	0	0	0	10,736	26
27	Other (specify):*	(125,500)	0	0	0	0	0	0	0	0	0	0	(125,500)	27
28	<b>TOTAL General Administration</b>	<b>(171,475)</b>	<b>10,736</b>	<b>0</b>	<b>(160,739)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(171,613)</b>	<b>10,736</b>	<b>0</b>	<b>(160,877)</b>	<b>29</b>								

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number CAMBRIDGE NURSING REHAB CENTER# 0048959

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	(30,031)	138,964	0	0	0	0	0	0	0	0	0	108,933	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,323)	473,145	0	0	0	0	0	0	0	0	0	464,822	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(513,215)	0	0	0	0	0	0	0	0	0	(513,215)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	37,879	0	0	0	0	0	0	0	0	0	37,879	36
37	<b>TOTAL Ownership</b>	<b>(38,354)</b>	<b>136,773</b>	<b>0</b>	<b>98,419</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>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(209,967)	147,509	0	0	0	0	0	0	0	0	0	(62,458)	45

**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
MARK APPEL	50	SKOKIE MEADOWS NURSING CENTER #2	SKOKIE	SKOKIE CAMBRIDGE		
JOAN WILLEY	50			REALTY, LLC	SKOKIE	REAL ESTATE

**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	\$ 513,215	SKOKIE CAMBRIDGE REALTY LLC		\$	(513,215)	1	
2	V	26 PROPERTY INSURANCE				10,736	10,736	2	
3	V	30 DEPRECIATION				138,964	138,964	3	
4	V	32 INTEREST				473,145	473,145	4	
5	V	36 MIP INSURANCE				37,879	37,879	5	
6	V							6	
7	V							7	
8	V							8	
9	V							9	
10	V							10	
11	V							11	
12	V							12	
13	V							13	
14	Total		\$ 513,215			\$ 660,724	\$ *	147,509	14

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

Facility Name & ID Number CAMBRIDGE NURSING REHAB CENTE # 0048959 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MARK APPEL	CFO	FINANCIAL	50.00				MGMT FEES	\$ 312,000	17-3	1
2						SEE					2
3	JOAN WILLEY	CEO	ADMINISTRATIV	50.00	skokie meadows	ATTACHED					3
4					nursing center #2	SCHEDULE					4
5					312,000						5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 312,000		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 CENTER

# 0048959

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization SKOKIE CAMBRIDGE REALTY, LLC  
 Street Address 9615 N KNOX  
 City / State / Zip Code SKOKIE ILLINOIS 60076  
 Phone Number ( 847 ) 679-4161  
 Fax Number ( 847 ) 679-3241

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	PROPERTY INSURANCE	DIRECT	1	\$ 10,736	\$	1	\$ 10,736	1
2	30	DEPRECIATION	DIRECT	1	138,964		1	138,964	2
3	32	INTEREST	DIRECT	1	473,145		1	473,145	3
4	36	MIP INSURANCE	DIRECT	1	37,879		1	37,879	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				\$ 660,724	\$		\$ 660,724	25

Facility Name &amp; ID Number

CAMBRIDGE NURSING REHAB CENTER

# 0048959

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

## 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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	HUD		X	MORTGAGE	\$37,760.00	10/17/07	\$ 6,822,050	\$ 6,687,708	11/1/42	5.7500	\$ 386,255	1								
2	HUD		X	HUD 2ND MORTGAGE		7/24/07	835,500	808,802	9/1/36	5.9500	48,198	2								
3	JACOB GRAF		X	WORKING CAPITAL	\$8,333.00	11/1/07	773,986	419,345	2/1/15	7.0000	32,555	3								
4	DIAMOND BANK		X	WORKING CAPITAL	\$3,700.00		200,000	122,034	12/24/12	4.2500	6,137	4								
5												5								
<b>Working Capital</b>																				
6												6								
7	DIAMOND BANK		X	WORKING CAPITAL	INTEREST ON	11/1/07	1,200,000	272,757	4/15/10	6.0000	18,739	7								
8												8								
9	<b>TOTAL Facility Related</b>				\$49,793.00		\$ 9,831,536	\$ 8,310,646			\$ 491,884	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>						\$	\$			\$	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 9,831,536	\$ 8,310,646			\$ 491,884	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 37,879 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.)







Facility Name &amp; ID Number CAMBRIDGE NURSING REHAB CENTER

# 0048959

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

**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	2007		\$ 2,365,250	\$ 60,647	39	\$ 60,647	\$	\$ 131,402	4
5										5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	CARPENTRY-LANDLORD		2007	83,324	2,137	39	2,137		4,630	9
10	WINDOWS- LANDLORD		2007	24,779	635	39	635		1,376	10
11	DRYWALL- LANDLORD		2007	3,685	95	39	95		206	11
12	FLOORING- LANDLORD		2007	80,961	2,076	39	2,076		4,498	12
13	PAINTING & DECORATING- LANDLORD		2007	119,994	3,076	39	3,076		6,665	13
14	SPECIAL EQUIPMENT- LANDLORD		2007	10,521	270	39	270		585	14
15	BLINDS & SHADES- LANDLORD		2007	6,170	158	39	158		342	15
16	CARPETS- LANDLORD		2007	6,133	157	39	157		340	16
17	SPECIAL CONSTRUCTION- LANDLORD		2007	14,852	381	39	381		826	17
18	ELECTRICAL- LANDLORD		2007	20,219	519	39	519		1,124	18
19	GENERAL REQUIREMENTS- LANDLORD		2007	36,552	937	39	937		2,030	19
20	BUILDERS OVERHEAD- LANDLORD		2007	8,143	209	39	209		453	20
21	BUILDERS PROFIT- LANDLORD		2007	40,719	1,044	39	1,044		2,262	21
22	ARCHITECT- LANDLORD		2007	22,320	572	39	572		1,239	22
23	INTEREST THRU PROJECT- LANDLORD		2007	3,698	95	39	95		206	23
24	CONSTRUCTION CHANGE- LANDLORD		2007	194	5	39	5		11	24
25	ARCHITECT- LANDLORD		2007	5,580	143	39	143		310	25
26										26
27	HOT WATER LINE		2008	4,330	104	39	104		130	27
28	COILER SYSTEM		2008	131,000	3,366	39	3,366		4,208	28
29										29
30	NEW PUMPS		2009	5,837	143	39	143		143	30
31	BOILER REMOVAL & REPLACE PUMP		2009	4,730	116	39	116		116	31
32	NEW BASEBOARD HEATING		2009	17,028	418	39	418		418	32
33	DRAINS & CONCRETE		2009	4,850	119	39	119		119	33
34	NEW HOT WATER COIL		2009	2,693	66	39	66		66	34
35	SPRINKLER SYSTEM		2009	5,980	148	39	148		148	35
36										36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 3,029,542	\$ 77,636		\$ 77,636	\$	\$ 163,853	70

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

Facility Name & ID Number CAMBRIDGE NURSING REHAB CENTER

# 0048959

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	\$ 66,128	\$ 13,226	\$ 6,613	\$ (6,613)	10	\$ 9,919	71
72	Current Year Purchases	73,519	7,352	3,676	(3,676)	10	3,676	72
73	Fully Depreciated Assets							73
74	<b>RELATED PARTY</b>	460,656	65,808	46,066	(19,742)	10	142,584	74
75	TOTALS	\$ 600,303	\$ 86,386	\$ 56,355	\$ (30,031)		\$ 156,179	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	ADMINISTRATOR	2008 LEXUS ES 350	2008	\$ 40,658	\$ 13,553	\$ 13,553	\$	3	\$ 27,106	76
77										77
78										78
79										79
80	TOTALS			\$ 40,658	\$ 13,553	\$ 13,553	\$		\$ 27,106	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)	\$ 3,945,753	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 177,575	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 147,544	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (30,031)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 347,138	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:				\$			3
4	Additions				513,215			4
5								5
6								6
7	TOTAL				\$ 513,215			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: \$ 45,281 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18	TRANSPORT RESIDENT	2005 FORD E350	398.33	4,780	18
19	& STAFF				19
20					20
21	TOTAL		\$ 398.33	\$ 4,780	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. \_\_\_\_\_/2010 \$ \_\_\_\_\_

13. \_\_\_\_\_/2011 \$ \_\_\_\_\_

14. \_\_\_\_\_/2012 \$ \_\_\_\_\_

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

**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	\$		\$ 183,836	\$		\$ 183,836	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			32,626			32,626	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			169,186			169,186	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				236,750		236,750	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					22,545			22,545	13
14	<b>TOTAL</b>			\$		\$ 408,193	\$ 236,750		\$ 644,943	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.

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

As of **12/31/2009** (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>(180,500)</u> )	<b>655,755</b>		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	<b>3,500</b>		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <b>Due From Landlord</b>	<b>907,928</b>		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	<b>\$ 1,567,183</b>	<b>\$</b>	<b>10</b>
<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	<b>176,448</b>		15
16	Equipment, at Historical Cost	<b>180,305</b>		16
17	Accumulated Depreciation (book methods)	<b>(46,133)</b>		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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	<b>\$ 310,620</b>	<b>\$</b>	<b>24</b>
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	<b>\$ 1,877,803</b>	<b>\$</b>	<b>25</b>

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	<b>\$ 361,292</b>	<b>\$</b>	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	<b>326,757</b>		29
30	Accrued Salaries Payable	<b>74,720</b>		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	<b>240,000</b>		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<b>Due to Skokie 2</b>	<b>913,972</b>		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	<b>\$ 1,916,741</b>	<b>\$</b>	<b>38</b>
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	<b>\$</b>	<b>\$</b>	<b>45</b>
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	<b>\$ 1,916,741</b>	<b>\$</b>	<b>46</b>
47	<b>TOTAL EQUITY(page 18, line 24)</b>	<b>\$ (38,938)</b>	<b>\$</b>	<b>47</b>
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	<b>\$ 1,877,803</b>	<b>\$</b>	<b>48</b>

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</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>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>121,062</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>(160,000)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(38,938)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(38,938)</b>	<b>24</b> *

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

Facility Name &amp; ID Number CAMBRIDGE NURSING REHAB CENTER

# 0048959

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

**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	\$ 6,132,841	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 6,132,841	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	143,542	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 143,542	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	371	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>	\$ 371	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	8,323	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 8,323	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 6,285,077	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,075,690	31
32	Health Care	2,049,630	32
33	General Administration	1,476,179	33
<b>B. Capital Expense</b>			
34	Ownership	855,705	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	644,943	35
36	Provider Participation Fee	61,868	36
<b>D. Other Expenses (specify):</b>			
37	<b>OUT-OF-PERIOD EXPENSES</b>		37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,164,015	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	121,062	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 121,062	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 PREPARED ON CASH BASIS

\*\*\* 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**

# **0048959**

Report Period Beginning: **01/01/2009**

Ending:

**12/31/2009**

**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	1,936	2,141	\$ 85,674	\$ 40.02	1
2	Assistant Director of Nursing	1,936	2,134	79,170	37.10	2
3	Registered Nurses	22,776	25,067	714,109	28.49	3
4	Licensed Practical Nurses	7,180	7,593	190,434	25.08	4
5	CNAs & Orderlies	50,884	54,567	494,132	9.06	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,672	1,728	33,340	19.29	9
10	Activity Assistants	5,850	6,344	57,261	9.03	10
11	Social Service Workers	5,484	5,988	111,330	18.59	11
12	Dietician					12
13	Food Service Supervisor	2,016	2,080	40,248	19.35	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,130	23,423	264,226	11.28	15
16	Dishwashers					16
17	Maintenance Workers	1,864	2,080	32,430	15.59	17
18	Housekeepers	9,203	9,943	107,307	10.79	18
19	Laundry	15,512	17,280	185,659	10.74	19
20	Administrator	320	440	17,464	39.69	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,728	10,672	174,645	16.36	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)	1,697	1,985	23,225	11.70	30
31	Medical Records	157	168	1,521	9.05	31
32	Other Health C: <u>MDS</u>	3,668	3,853	102,967	26.72	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	163,013	177,486	\$ 2,715,142 *	\$ 15.30	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	260	\$ 11,970	1-3	35
36	Medical Director	60	12,000	9-3	36
37	Medical Records Consultant	72	4,320	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	MONTHLY	1,766	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	46	1,824	11-3	44
45	Social Service Consultant	88	3,528	12-3	45
46	Other(specify) <u>PHYSICIANS</u>	MONTHLY	12,000		46
47	<u>PSYCHIATRIC</u>		80		47
48					48
49	TOTAL (lines 35 - 48)	526	\$ 47,488		49

**C. CONTRACT NURSES**

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





Facility Name &amp; ID Number CAMBRIDGE NURSING REHAB CENTER

# 0048959

Report Period Beginning: 01/01/2009 Ending: 12/31/2009

## 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. ICLTC \$9017 IL.ASSOC.HEALTHCARE \$1332
- (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. \$ NO 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 X 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. \$ 61,868  
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: \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES  
Attach invoices and a summary of services for all architect and appraisal fees.