



Facility Name & ID Number CAMBRIDGE NURSING REHAB CTR

# 0048959 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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			3,699	3,699	8
9	SNF/PED					9
10	ICF	27,934	2,688	1,698	32,320	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,934	2,688	5,397	36,019	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.33%

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 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 \_\_\_\_\_ and days of care provided 3,699

Medicare Intermediary NGS

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2013 Fiscal Year: 12/31/2013

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

Facility Name &amp; ID Number

CAMBRIDGE NURSING REHAB CTR

# 0048959

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

**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	347,499	15,530	10,926	373,955		373,955	373,955			1
2	Food Purchase		213,648		213,648	(23,769)	189,879	(226)	189,653		2
3	Housekeeping	188,342	25,113		213,455		213,455	213,455			3
4	Laundry	128,912	26,190	207	155,309		155,309	155,309			4
5	Heat and Other Utilities			64,806	64,806		64,806	64,806			5
6	Maintenance	32,430	29,096	102,135	163,661		163,661	163,661			6
7	Other (specify):*			12,143	12,143		12,143	12,143			7
8	<b>TOTAL General Services</b>	697,183	309,577	190,217	1,196,977	(23,769)	1,173,208	(226)	1,172,982		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	1,866,662	80,979	37,714	1,985,355		1,985,355	1,985,355			10
10a	Therapy										10a
11	Activities	106,435	13,549	1,320	121,304		121,304	121,304			11
12	Social Services	109,556		8,295	117,851		117,851	117,851			12
13	CNA Training										13
14	Program Transportation			2,708	2,708		2,708	2,708			14
15	Other (specify):* CARE PLAN	60,670			60,670		60,670	60,670			15
16	<b>TOTAL Health Care and Programs</b>	2,143,323	94,528	62,037	2,299,888		2,299,888	2,299,888			16
	<b>C. General Administration</b>										
17	Administrative	44,100		150,000	194,100		194,100	194,100			17
18	Directors Fees										18
19	Professional Services			73,172	73,172		73,172	73,172			19
20	Dues, Fees, Subscriptions & Promotions			63,444	63,444		63,444	(22,077)	41,367		20
21	Clerical & General Office Expenses	173,764	11,381	5,778	190,923		190,923	190,923			21
22	Employee Benefits & Payroll Taxes			567,408	567,408	23,769	591,177	591,177			22
23	Inservice Training & Education			888	888		888	888			23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			8,421	8,421		8,421	8,421			25
26	Insurance-Prop.Liab.Malpractice			72,202	72,202		72,202	13,484	85,686		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	217,864	11,381	941,313	1,170,558	23,769	1,194,327	(8,593)	1,185,734		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,058,370	415,486	1,193,567	4,667,423		4,667,423	(8,819)	4,658,604		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	10,926
	REPAIRS & MAINTENANCE	0
		0
		10,926
3	<b>HOUSEKEEPING</b>	
		0
		0
		0
4	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	0
	OUTSIDE LABOR	207
		207
5	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	18,522
	ELECTRICITY	21,604
	WATER	18,664
	CABLE TV - LOBBY	6,016
		0
		64,806
6	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	2,400
	PAINTING & DECORATING	17,795
	BUILDING REPAIRS	23,217
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	19,682
	ELEVATOR MAINTENANCE & REPAIR	14,387
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	3,375
	FIRE SERVICE	13,103
	CONTRACTED BUILDING MAINT	8,176
		0
		0
		0
		102,135
7	<b>OTHER</b>	
	SCAVENGER	9,094
	SECURITY SERVICE	3,049
		0
		0
		12,143
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	5,955
	PURCHASED SERVICES	4,108
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	4,512
	PHARMACY CONSULTANT XVIII B 39-2	4,908
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	18,000
	PSYCHIATRIC XVIII B __-2	80
	RN CONSULTANT XVIII B 38-2	0
	DENTAL	151
		0
		37,714
10a	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	1,320
		0
		1,320
12	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	8,295
		8,295
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		2,708
			0
17	<b>ADMINISTRATIVE</b>		
	MANAGEMENT FEES	XIX B	150,000
18	<b>DIRECTORS FEES</b>		
	DIRECTORS FEES		0
19	<b>PROFESSIONAL SERVICES</b>		
	DATA PROCESSING	XIX C	2,298
	ADMINISTRATIVE CONSULTANTS	XIX C	0
	PROFESSIONAL FEES	XIX C	70,874
			0
			73,172
20	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>		
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	17,747
	EMPLOYEE WANT ADS	XIX F	6,160
	CONTRIBUTIONS	VI 20 XIX F	0
	DUES & SUBSCRIPTIONS	XIX F	26,750
	LICENSES & PERMITS	XIX F	8,457
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	4,330
	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
			63,444
21	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>		
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		70
	EQUIPMENT REPAIR & MAINTENANCE		0
	OUTSIDE CLERICAL SERVICES		618
	PENALTIES / OVERDRAFT CHARGES	VI 18	0
	HOME OFFICE EXPENSE		0
	THEFT & DAMAGE LOSS		0
	TELEPHONE		5,090
	MESSENGER SERVICE		0
			0
			5,778

LINE		SCHED REF	TOTAL
22	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>		
	FICA TAXES	XIX D	232,405
	UNEMPLOYMENT COMPENSATION	XIX D	14,876
	WORKERS COMPENSATION INSURANC	XIX D	81,983
	HOSPITALIZATION INSURANCE	XIX D	200,143
	EMPLOYEE BENEFITS - OTHER	XIX D	3,682
	EMPLOYEE PHYSICAL EXAMS	XIX D	3,634
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS	XIX D	30,685
	CHICAGO HEAD TAX	XIX D	0
			0
			567,408
23	<b>INSERVICE TRAINING &amp; EDUCATION</b>		
	EDUCATION & SEMINARS		888
			888
24	<b>TRAVEL &amp; SEMINARS</b>		
	EDUCATION & SEMINARS	XIX G	0
	TRAVEL	XIX G	0
			0
25	<b>ADMIN. STAFF TRANSPORTATION</b>		
	TRANSPORTATION - STAFF		8,421
			8,421
26	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>		
	GENERAL INSURANCE		72,202
			72,202
27	<b>OTHER</b>		
	BAD DEBTS	VI 24	0
			0

GRAND TOTAL COLUMN 3 OTHER

1,193,567

**CAMBRIDGE NURSING REHAB CTR  
SCHEDULES  
12/31/2013**

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

TOTAL FOOD PURCHASE	213,648
LESS SALES TAX	<u>(226)</u>
NET FOOD	213,422
TOTAL PATIENT CENSUS	36,019
TIMES 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	108,057
ADD # EMPLOYEE MEALS/DAY	37
TIMES # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	13,505
PATIENT MEALS	108,057
ADD EMPLOYEE MEALS	<u>13,505</u>
TOTAL MEALS/YEAR	121,562
NET FOOD	213,422
DIVIDE TOTAL MEALS/YEAR	<u>121,562</u>
COST PER MEAL	1.76
TIMES EMPLOYEE MEALS	<u>13,505</u>
EMPLOYEE MEAL RECLASSIFICATION	<u><u>23,769</u></u>

Facility Name &amp; ID Number

CAMBRIDGE NURSING REHAB CTR

#0048959

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

## 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			50,601	50,601	50,601	119,475	170,076				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,605	2,605	2,605	176,559	179,164				32
33	Real Estate Taxes			274,291	274,291	274,291		274,291				33
34	Rent-Facility & Grounds			667,035	667,035	667,035	(667,035)					34
35	Rent-Equipment & Vehicles			60,363	60,363	60,363		60,363				35
36	Other (specify):*						43,902	43,902				36
37	<b>TOTAL Ownership</b>			1,054,895	1,054,895	1,054,895	(327,099)	727,796				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		136,624	417,759	554,383	554,383		554,383				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			256,345	256,345	256,345		256,345				42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		136,624	674,104	810,728	810,728		810,728				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,058,370	552,110	2,922,566	6,533,046	6,533,046	(335,918)	6,197,128				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	(6,980)	30		9
10	Interest and Other Investment Income	(648)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(226)	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		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(17,747)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(4,330)	20		28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (29,931)		\$	30

<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)	(305,987)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (305,987)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (335,918)		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

CAMBRIDGE NURSING REHAB CTR

ID# 0048959

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

Sch. V Line

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

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>		0	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number CAMBRIDGE NURSING REHAB CTR# 0048959

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(226)	0	0	0	0	0	0	0	0	0	0	(226)	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>(226)</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>(226)</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	(22,077)	0	0	0	0	0	0	0	0	0	0	(22,077)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	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	13,484	0	0	0	0	0	0	0	0	0	13,484	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(22,077)</b>	<b>13,484</b>	<b>0</b>	<b>(8,593)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(22,303)</b>	<b>13,484</b>	<b>0</b>	<b>(8,819)</b>	<b>29</b>								

## STATE OF ILLINOIS

Facility Name & ID Number CAMBRIDGE NURSING REHAB CTR# 0048959

Report Period Beginning:

01/01/2013 Ending:

Summary B

12/31/2013

## 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	(6,980)	126,455	0	0	0	0	0	0	0	0	0	119,475	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(648)	177,207	0	0	0	0	0	0	0	0	0	176,559	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(667,035)	0	0	0	0	0	0	0	0	0	(667,035)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	43,902	0	0	0	0	0	0	0	0	0	43,902	36
37	<b>TOTAL Ownership</b>	<b>(7,628)</b>	<b>(319,471)</b>	<b>0</b>	<b>(327,099)</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)	(29,931)	(305,987)	0	0	0	0	0	0	0	0	0	(335,918)	45

**VII. RELATED PARTIES**

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 RENT	\$ 667,035	SKOKIE CAMBRIDGE REALTY LLC		\$	\$ (667,035)	1
2	V	26 INSURANCE				13,484	13,484	2
3	V	30 DEPRECIATION				126,455	126,455	3
4	V	32 INTEREST				171,914	171,914	4
5	V	36 MIP INSURANCE				43,902	43,902	5
6	V	32 AMORT OF LOAN COST				5,293	5,293	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 667,035			\$ 361,048	\$ * (305,987)	14

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

Facility Name & ID Number

CAMBRIDGE NURSING REHAB CTR

# 0048959

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

VII. RELATED PARTIES

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

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

Facility Name & ID Number CAMBRIDGE NURSING REHAB CTR # 0048959 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

## 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	\$ 150,000	17-3	1
2											2
3	JOAN WILLEY	CEO	ADMINISTRATIVE	50.00	150,000			MGMT FEES			3
4					SKOKIE MEADOWS NURSING CENTER #2						4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 150,000		13

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

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

Facility Name & ID Number CAMBRIDGE NURSING REHAB CTR

# 0048959

Report Period Beginning: 01/01/2013

Ending: 2/31/2013

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

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

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

1	Name of Lender	2		3	4	5	6		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	SKOKIE CAMBRIDGE REALTY, LLC						\$	\$		\$	1						
2	CAMBRIDGE REALTY		X	MORTGAGE		12/21/12		7,085,816	11/01/42	2.4000	171,914						
3	LOAN COST		X	AMORTIZE OVER LIFE OF LOAN			79,398	79,398			5,293						
4											4						
5											5						
<b>Working Capital</b>																	
6	DIAMOND BANK		X	WORKING CAPITAL	INT. ONLY	4/15/11				6.0000	2,605						
7											7						
8											8						
9	<b>TOTAL Facility Related</b>						\$ 79,398	\$ 7,165,214			\$ 179,812						
<b>B. Non-Facility Related*</b>																	
10											10						
11											11						
12											12						
13											13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$						
15	<b>TOTALS (line 9+line14)</b>						\$ 79,398	\$ 7,165,214			\$ 179,812						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 43,902 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.)





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

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

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

**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 REHAB CTR

# 0048959

Report Period Beginning:

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	113			2007	\$ 2,365,250	\$ 60,647	39	\$ 60,647	\$	\$ 373,990	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		CARPENTRY-LANDLORD		2007	83,324		39	2,137	2,137	13,178	9
10		WINDOWS- LANDLORD		2007	24,779		39	635	635	3,916	10
11		DRYWALL- LANDLORD		2007	3,685		39	95	95	586	11
12		FLOORING- LANDLORD		2007	80,961		39	2,076	2,076	12,802	12
13		PAINTING & DECORATING- LANDLORD		2007	119,994		39	3,076	3,076	18,969	13
14		SPECIAL EQUIPMENT- LANDLORD		2007	10,521		39	270	270	1,665	14
15		BLINDS & SHADES- LANDLORD		2007	6,170		39	158	158	974	15
16		CARPETS- LANDLORD		2007	6,133		39	157	157	968	16
17		SPECIAL CONSTRUCTION- LANDLORD		2007	14,852		39	381	381	2,350	17
18		ELECTRICAL- LANDLORD		2007	20,219		39	519	519	3,200	18
19		GENERAL REQUIREMENTS- LANDLORD		2007	36,552		39	937	937	5,778	19
20		BUILDERS OVERHEAD- LANDLORD		2007	8,143		39	209	209	1,289	20
21		BUILDERS PROFIT- LANDLORD		2007	40,719		39	1,044	1,044	6,438	21
22		ARCHITECT- LANDLORD		2007	22,320		39	572	572	3,527	22
23		INTEREST THRU PROJECT- LANDLORD		2007	3,698		39	95	95	586	23
24		CONSTRUCTION CHANGE- LANDLORD		2007	194		39	5	5	31	24
25		ARCHITECT- LANDLORD		2007	5,580		39	143	143	882	25
26											26
27		HOT WATER LINE		2008	4,330	104	39	104		546	27
28		COILER SYSTEM		2008	131,000	3,366	39	3,366		17,672	28
29											29
30		NEW PUMPS		2009	5,837	150	39	150		743	30
31		BOILER REMOVAL & REPLACE PUMP		2009	4,730	121	39	121		600	31
32		NEW BASEBOARD HEATING		2009	17,028	437	39	437		2,166	32
33		DRAINS & CONCRETE		2009	4,850	124	39	124		615	33
34		NEW HOT WATER COIL		2009	2,693	69	39	69		342	34
35		SPRINKLER SYSTEM		2009	5,980	153	39	153		760	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number CAMBRIDGE NURSING REHAB CTR

# 0048959

Report Period Beginning:

01/01/2013 Ending: 12/31/2013

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	NEW MOTORIZED VALVE BODY AND MOTOR	2010	\$ 11,686	\$ 299	39	\$ 299	\$	\$ 1,184	37
38	NEW SEDIMENT/AIR REMOVING DEVICE	2010	7,535	193	39	193		764	38
39	NEW BLATER TANKS	2010	5,023	129	39	129		510	39
40	FIRE ALARM SYSTEM	2010	18,293	469	39	469		1,857	40
41	FIRE SCAPE	2010	2,500	64	39	64		254	41
42	DISH ROOM WALLS REPAIR	2010	3,800	97	39	97		384	42
43	CAULK WINDOWS	2010	2,600	67	39	67		265	43
44	DRYER VENTING	2010	3,733	96	39	96		380	44
45	HEATING SYSTEM	2010	21,014	539	39	539		2,133	45
46									46
47	ADMIN. ASS. SUSPENDED CEILING	2011	3,188	82	39	82		246	47
48	NURSE OFFICE SUSPENDED CEILING	2011	2,929	75	39	75		225	48
49	REPAIR KITCHEN WALL	2011	3,500	90	39	90		270	49
50	remove & replaced drywall, tiling, then repaint staff bathroom	2011	3,973	102	39	102		306	50
51	remove & replaced drywall, tiling, then repaint public bathroom	2011	4,221	108	39	108		324	51
52	KITCHEN DOORS AND WALL REPLACEMENT	2011	8,934	229	39	229		687	52
53	WALLPAPER	2011	1,800	46	39	46		138	53
54									54
55	replace exterior kitchen door and replace wall behind stove	2012	5,228	134	39	134		263	55
56	remodeling of doorway and doors to the kitchen	2012	7,975	205	39	205		401	56
57									57
58	Remodeling of Dish Room and Part of Kitchen Walls	2013	11,050	271	39	271		271	58
59	Dining Room Remodeling	2013	13,540	333	39	333		333	59
60	Flooring In Therapy Room	2013	11,986	295	39	295		295	60
61	Tankless Water Heater	2013	25,000	614	39	614		614	61
62	Piping	2013	26,913	661	39	661		661	62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,235,963	\$ 70,369		\$ 82,878	\$ 12,509	\$ 487,338	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 204,937	\$ 22,968	\$ 20,494	\$ (2,474)	10	\$ 88,701	71
72	Current Year Purchases	17,911	17,911	896	(17,015)	10	896	72
73	Fully Depreciated Assets							73
74	RELATED PARTY		65,808	65,808				74
75	TOTALS	\$ 222,848	\$ 106,687	\$ 87,198	\$ (19,489)		\$ 89,597	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 3,734,061	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 177,056	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 170,076	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (6,980)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 576,935	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: N/A-RELATED PARTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.  YES  NO

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12. \_\_\_\_\_ \$ \_\_\_\_\_

13. \_\_\_\_\_ \$ \_\_\_\_\_

14. \_\_\_\_\_ \$ \_\_\_\_\_

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

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

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

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

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

16. Rental Amount for movable equipment: \$ 60,363 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

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

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

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

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

Facility Name & ID Number CAMBRIDGE NURSING REHAB CTR # 0048959 Report Period Beginning: 01/01/2013 Ending: 12/31/2013  
**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><b>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</b></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>
---	---	--

**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	SUM OF line 9, col. 1 and 2 (e)	\$			

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

<b>COMPLETED</b>		
1. From this facility		
2. From other facilities (f)		
<b>DROP-OUTS</b>		
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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39-3	hrs	\$		\$	124,041	\$		\$	124,041	1
2	Licensed Speech and Language Development Therapist	39-3	hrs				25,709				25,709	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39-3	hrs				268,009				268,009	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39-2	# of prescrpts					136,624			136,624	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify):											13
14	<b>TOTAL</b>			\$		\$	417,759	\$	136,624	\$	554,383	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 & ID Number CAMBRIDGE NURSING REHAB CTR# 0048959Report Period Beginning: 01/01/2013Ending: 12/31/2013

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2013

(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	\$ 1,235,792	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (180,500) )	1,448,867		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(1,061,179)		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,623,480	\$	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	382,869		15
16	Equipment, at Historical Cost	349,834		16
17	Accumulated Depreciation (book methods)	(378,706)		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): <u>Construction in Progress</u>	10,000		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 363,997	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,987,477	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 355,371	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	119,864		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	270,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>SKOKIE 1 &amp; 2 ELIMINATION</u>	576,953		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,322,188	\$	38
	<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>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,322,188	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 665,289	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,987,477	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 252,254	1
2	Restatements (describe):		2
3	SKOKIE 1 & 2 ELIMINATION	(444,008)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (191,754)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	1,162,043	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(305,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 857,043	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 665,289	24 *

\* 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	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 7,618,380	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 7,618,380	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	74,983	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 74,983	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>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	648	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 648	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Vending Commissions</b>	1,078	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,078	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 7,695,089	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,196,977	31
32	Health Care	2,299,888	32
33	General Administration	1,170,558	33
<b>B. Capital Expense</b>			
34	Ownership	1,054,895	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	554,383	35
36	Provider Participation Fee	256,345	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,533,046	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	1,162,043	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 1,162,043	43

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 4,869,768	44
45	Private Pay - Net Inpatient Revenue	453,253	45
46	Medicare - Net Inpatient Revenue	1,990,606	46
47	Other-(specify) <u>VETERAN</u>	304,753	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 7,618,380	49

**\*\*TAX RETURN PREPARED ON CASH BASIS**

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? NO\*\* If not, please attach a reconciliation.

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

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

Facility Name & ID Number **CAMBRIDGE NURSING REHAB CTR**

# **0048959**

Report Period Beginning: **01/01/2013**

Ending:

**12/31/2013**

**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	1,952	2,080	\$ 81,672	\$ 39.27	1
2	Assistant Director of Nursing	1,976	2,145	78,204	36.46	2
3	Registered Nurses	23,846	26,355	756,255	28.69	3
4	Licensed Practical Nurses	6,699	7,153	181,826	25.42	4
5	CNAs & Orderlies	61,714	65,901	699,515	10.61	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,992	2,080	40,248	19.35	9
10	Activity Assistants	5,542	6,142	66,187	10.78	10
11	Social Service Workers	5,148	5,643	109,556	19.41	11
12	Dietician					12
13	Food Service Supervisor	1,992	2,080	42,894	20.62	13
14	Head Cook					14
15	Cook Helpers/Assistants	24,460	26,885	304,605	11.33	15
16	Dishwashers					16
17	Maintenance Workers	1,848	2,080	32,430	15.59	17
18	Housekeepers	14,373	16,340	188,342	11.53	18
19	Laundry	9,855	11,543	128,912	11.17	19
20	Administrator	1,872	2,080	44,100	21.20	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,088	2,381	45,489	19.10	23
24	Clerical	7,469	8,211	128,275	15.62	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 C: <u>MDS</u>	1,904	2,080	69,190	33.26	32
33	Other(specify) <u>CARE PLANS</u>	1,944	2,080	60,670	29.17	33
34	TOTAL (lines 1 - 33)	176,674	193,259	\$ 3,058,370 *	\$ 15.83	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	202	\$ 10,926	1-3	35
36	Medical Director	30	12,000	9-3	36
37	Medical Records Consultant	74	4,512	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	109	4,908	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	22	1,320	11-3	44
45	Social Service Consultant	138	8,295	12-3	45
46	Other(specify) <u>PHYSICIANS</u>	15	18,000	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	590	\$ 59,961		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		N/A	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	
EUGCNE BGRGER	ADMINISTRATOR		\$ 44,100	Workers' Compensation Insurance	\$ 81,983	IDPH License Fee	\$	
				Unemployment Compensation Insurance	14,876	Advertising: Employee Recruitment	6,160	
				FICA Taxes	232,405	Health Care Worker Background Check	0	
				Employee Health Insurance	200,143	(Indicate # of checks performed)		
				Employee Meals	23,769	Patient Background Checks	0	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	0	
				EMPLOYEE BENEFITS - OTHER	3,682	MARKETING/ADV/PROMO	22,077	
				EMPLOYEE PHYSICAL EXAMS	3,634	LICENSES/DUES/SUBSCRIPTIONS	35,207	
				PENSION/PROFIT SHARING PLANS	30,685	MGMT CO ALLOC		
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	0	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	( 0 )	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(17,747)	
						Yellow page advertising	(4,330)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 44,100	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 591,177		\$ 41,367		
B. Administrative - Other			E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount
MARK APPEL	MANAGEMENT FEES		\$ 150,000				Out-of-State Travel	\$
							In-State Travel	0
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 150,000				Seminar Expense	0
							Entertainment Expense	( )
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 73,172	TOTAL		\$	TOTAL	\$

\* 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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8						N/A						
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name &amp; ID Number CAMBRIDGE NURSING REHAB CTR

# 0048959

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

## XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. IL. Council On Long Term Care \$8,695
- (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 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. \$ 256,345  
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. \$ 23,769 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.