FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0048959

Facility Name: CAMBRIDGE NURSING REHAB CENTER

Address: 9615 NORTH KNOX AVENUE (Number) SKOKIE (City) 60076 (Zip Code)

County: COOK

Telephone Number: (847) 679-4161 **Fax #** (847) 679-3241

HFS ID Number:

Date of Initial License for Current Owners: 11/1/07

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2010 to 12/31/2010 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) MARK APPEL
(Title) OWNER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, VICE PRESIDENT
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number CAMBRIDGE NURSING REHAB CENTER # 0048959 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			3,697	3,697	8
9	SNF/PED					9
10	ICF	27,201	3,192	2,848	33,241	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,201	3,192	6,545	36,938	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.56%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/01/07

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 113 and days of care provided 3,697

Medicare Intermediary NGS

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number CAMBRIDGE NURSING REHAB CENTER # 0048959 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	313,690	14,573	11,267	339,530		339,530		339,530			1
2	Food Purchase		180,370		180,370	(25,550)	154,820		154,820			2
3	Housekeeping	106,923	18,595		125,518		125,518		125,518			3
4	Laundry	198,922	22,086	270	221,278		221,278		221,278			4
5	Heat and Other Utilities			129,240	129,240		129,240		129,240			5
6	Maintenance	32,430	17,122	57,426	106,978		106,978		106,978			6
7	Other (specify):*			9,469	9,469		9,469		9,469			7
8	TOTAL General Services	651,965	252,746	207,672	1,112,383	(25,550)	1,086,833		1,086,833			8
	B. Health Care and Programs											
9	Medical Director			13,000	13,000		13,000		13,000			9
10	Nursing and Medical Records	1,928,661	60,921	61,668	2,051,250		2,051,250		2,051,250			10
10a	Therapy											10a
11	Activities	103,231	11,272	2,640	117,143		117,143		117,143			11
12	Social Services	120,761		4,735	125,496		125,496		125,496			12
13	CNA Training											13
14	Program Transportation			2,378	2,378		2,378		2,378			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,152,653	72,193	84,421	2,309,267		2,309,267		2,309,267			16
	C. General Administration											
17	Administrative	2,176		312,000	314,176		314,176		314,176			17
18	Directors Fees											18
19	Professional Services			81,618	81,618		81,618		81,618			19
20	Dues, Fees, Subscriptions & Promotions			64,497	64,497		64,497	(36,813)	27,684			20
21	Clerical & General Office Expenses	128,118	9,917	7,709	145,744		145,744		145,744			21
22	Employee Benefits & Payroll Taxes			484,119	484,119	25,550	509,669		509,669			22
23	Inservice Training & Education			1,158	1,158		1,158		1,158			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			6,066	6,066		6,066		6,066			25
26	Insurance-Prop.Liab.Malpractice			62,269	62,269		62,269	10,759	73,028			26
27	Other (specify):*											27
28	TOTAL General Administration	130,294	9,917	1,019,436	1,159,647	25,550	1,185,197	(26,054)	1,159,143			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,934,912	334,856	1,311,529	4,581,297		4,581,297	(26,054)	4,555,243			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.

Facility Name & ID#: CAMBRIDGE NURSING REHAB CENTER #0048959 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	11,267	
	REPAIRS & MAINTENANCE		0	
			0	11,267
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
	OUTSIDE LABOR		270	270
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		54,451	
	ELECTRICITY		49,688	
	WATER		19,481	
	CABLE TV - LOBBY		5,620	
			0	129,240
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		800	
	PAINTING & DECORATING		11,683	
	BUILDING REPAIRS		11,997	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		12,686	
	ELEVATOR MAINTENANCE & REPAIR		7,450	
	OUTSIDE LABOR			
	EXTERMINATING SERVICE		3,471	
	FIRE SERVICE		3,785	
	CONTRACTED BUILDING MAINT.		5,554	
			0	
			0	
			0	57,426
7	**OTHER**			
	SCAVENGER		9,469	
	SECURITY SERVICE		0	
			0	
			0	9,469
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	13,000	13,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		10,788	
	PURCHASED SERVICES		32,664	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	4,416	
	PHARMACY CONSULTANT	XVIII B 39-2	1,800	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	12,000	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	61,668
10a	**THERAPY**			
	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 CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS			
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,640	
			0	2,640
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES			
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	4,735	
			0	4,735
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number CAMBRIDGE NURSING REHAB CENTER **#0048959** **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		2,378	2,378
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	312,000	312,000
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	4,223	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	77,395	
			0	81,618
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	28,175	
	EMPLOYEE WANT ADS	XIX F	4,621	
	CONTRIBUTIONS	VI 20 XIX F	150	
	DUES & SUBSCRIPTIONS	XIX F	15,807	
	LICENSES & PERMITS	XIX F	5,886	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	4,296	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	4,192	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	850	
	PATIENT BACKGROUND CHECKS	XIX F	520	
				64,497
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		153	
	EQUIPMENT REPAIR & MAINTENANCE		0	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		7,556	
	MESSENGER SERVICE		0	
			0	7,709

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	221,716	
	UNEMPLOYMENT COMPENSATION	XIX D	16,095	
	WORKERS COMPENSATION INSURANC	XIX D	0	
	HOSPITALIZATION INSURANCE	XIX D	205,867	
	EMPLOYEE BENEFITS - OTHER	XIX D	2,850	
	EMPLOYEE PHYSICAL EXAMS	XIX D	2,422	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	35,169	
	CHICAGO HEAD TAX	XIX D	0	
			0	484,119
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		1,158	
				1,158
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G		
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		6,066	
				6,066
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		62,269	
				62,269
27	**OTHER**			
	BAD DEBTS	VI 24	0	
				0

GRAND TOTAL COLUMN 3 OTHER **1,311,529**

CAMBRIDGE NURSING REHAB CENTER
SCHEDULES
12/31/2010

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

TOTAL FOOD PURCHASE	180,370
LESS SALES TAX	0
NET FOOD	180,370
TOTAL PATIENT CENSUS	36,938
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	110,814
ADD # EMPLOYEE MEALS/DAY	50
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	18,250
PATIENT MEALS	110,814
ADD EMPLOYEE MEALS	18,250
TOTAL MEALS/YEAR	129,064
NET FOOD	180,370
DIVIDE TOTAL MEALS/YEAR	129,064
COST PER MEAL	1.40
TIME EMPLOYEE MEALS	18,250
EMPLOYEE MEAL RECLASSIFICATION	**25,550**
	========

HAVE YOU FORGOTTEN TO ENTER SALES TAX ON PAGE 5??

Facility Name & ID Number CAMBRIDGE NURSING REHAB CENTER #0048959 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			136,547	136,547		136,547	48,386	184,933			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8,839	8,839		8,839	462,540	471,379			32
33	Real Estate Taxes			162,021	162,021		162,021		162,021			33
34	Rent-Facility & Grounds			963,215	963,215		963,215	(963,215)				34
35	Rent-Equipment & Vehicles			50,917	50,917		50,917		50,917			35
36	Other (specify):*							37,447	37,447			36
37	**TOTAL Ownership**			1,321,539	1,321,539		1,321,539	(414,842)	906,697			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		221,479	420,100	641,579		641,579		641,579			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	**TOTAL Special Cost Centers**		221,479	481,968	703,447		703,447		703,447			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,934,912	556,335	3,115,036	6,606,283		6,606,283	(440,896)	6,165,387			45

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

Facility Name & ID Number CAMBRIDGE NURSING REHAB CENTER # 0048959 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(90,578)	30		9
10	Interest and Other Investment Income	(136)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		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	(4,342)	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	(28,175)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(4,296)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (127,527)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(313,369)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (313,369)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (440,896)		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

CAMBRIDGE NURSING REHAB CENTER

ID# 0048959

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CAMBRIDGE NURSING REHAB CENTER # 0048959 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(36,813)	0	0	0	0	0	0	0	0	0	0	(36,813)	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	10,759	0	0	0	0	0	0	0	0	0	10,759	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(36,813)	10,759	0	0	0	0	0	0	0	0	0	(26,054)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(36,813)	10,759	0	0	0	0	0	0	0	0	0	(26,054)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CAMBRIDGE NURSING REHAB CENTER # 0048959 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(90,578)	138,964	0	0	0	0	0	0	0	0	0	48,386	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(136)	462,676	0	0	0	0	0	0	0	0	0	462,540	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(963,215)	0	0	0	0	0	0	0	0	0	(963,215)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	37,447	0	0	0	0	0	0	0	0	0	37,447	36
37	**TOTAL Ownership**	(90,714)	(324,128)	0	0	0	0	0	0	0	0	0	(414,842)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(127,527)	(313,369)	0	0	0	0	0	0	0	0	0	(440,896)	45

Facility Name & ID Number CAMBRIDGE NURSING REHAB CENTER # 0048959 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 REALTY, LLC	SKOKIE	REAL ESTATE
JOAN WILLEY	50					

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	$ 963,215	SKOKIE CAMBRIDGE REALTY LLC		$	$ (963,215)	1
2	V	26	INSURANCE				10,759	10,759	2
3	V	30	DEPRECIATION				138,964	138,964	3
4	V	32	INTEREST				462,676	462,676	4
5	V	36	MIP INSURANCE				37,447	37,447	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			$ 963,215			$ 649,846	$ * (313,369)	14

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

Facility Name & ID Number CAMBRIDGE NURSING REHAB CENTEI # 0048959 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	MARK APPEL	CFO	FINANCIAL					MGMT FEES	$ 312,000	17-3	1
2											2
3	JOAN WILLEY	CEO	ADMINISTRATIVE		312,000						3
4					SKOKIE MEADOWS						4
5					NURSING CENTER #2						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: 01/01/2010 Ending: 2/31/2010

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	26	PROPERTY INSURANCE	DIRECT	1	1	$ 10,759	$	1	$ 10,759	1
2	30	DEPRECIATION	DIRECT	1	1	138,964		1	138,964	2
3	32	INTEREST	DIRECT	1	1	462,676		1	462,676	3
4	36	MIP INSURANCE	DIRECT	1	1	37,447		1	37,447	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					$ 649,846	$		$ 649,846	25

Facility Name & ID Number CAMBRIDGE NURSING REHAB CENTER # 0048959 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	SKOKIE CAMBRIDGE REALTY, LLC						$	$			$	1
2	CAMBRIDGE REALTY		X	MORTGAGE	$37,760.00	10/17/07	6,822,050	6,617,293	11/1/42	5.7500	382,307	2
3	CAMBRIDGE REALTY		X	2ND MORTGAGE		7/24/07	835,500	796,178	9/1/36	5.9500	47,470	3
4	JACOB GRAF		X	WORKING CAPITAL	$8,333.00	11/1/07	773,986	347,463	2/1/15	7.0000	28,467	4
5	DIAMOND BANK		X	WORKING CAPITAL	$3,700.00		200,000	81,356	12/24/12	4.2500	4,432	5
	Working Capital											
6												6
7	DIAMOND BANK		X	WORKING CAPITAL		4/15/10			4/15/11	6.0000	8,839	7
8												8
9	TOTAL Facility Related				$49,793.00		$ 8,631,536	$ 7,842,290			$ 471,515	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 8,631,536	$ 7,842,290			$ 471,515	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 37,447 **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 & ID Number CAMBRIDGE NURSING REHAB CENTER # 0048959 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 240,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 175,021	2
3. Under or (over) accrual (line 2 minus line 1).		$ (64,979)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 227,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 162,021	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2005	8
	2006	9
	2007 221,368	10
	2008 227,079	11
	2009 175,021	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 130% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2009 TAX BILL.

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CAMBRIDGE NURSING REHAB CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0048959

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-10-304-007-0000	NURSING HOME	$ 29,167.42	$ 29,167.42
2.	10-10-304-008-0000	NURSING HOME	$ 29,170.71	$ 29,170.71
3.	10-10-304-009-0000	NURSING HOME	$ 29,170.71	$ 29,170.71
4.	10-10-304-010-0000	NURSING HOME	$ 29,170.71	$ 29,170.71
5.	10-10-304-011-0000	NURSING HOME	$ 29,170.71	$ 29,170.71
6.	10-10-304-012-0000	NURSING HOME	$ 29,170.71	$ 29,170.71
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 175,020.97	$ 175,020.97

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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 & ID Number CAMBRIDGE NURSING REHAB CENTER # 0048959 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,048 B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

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

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

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number CAMBRIDGE NURSING REHAB CENTER # 0048959 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	113		2007		$ 2,365,250	$ 60,647	39	$ 60,647	$	$ 192,049	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	CARPENTRY-LANDLORD			2007	83,324	2,137	39	2,137		6,767	9
10	WINDOWS- LANDLORD			2007	24,779	635	39	635		2,011	10
11	DRYWALL- LANDLORD			2007	3,685	95	39	95		301	11
12	FLOORING- LANDLORD			2007	80,961	2,076	39	2,076		6,574	12
13	PAINTING & DECORATING- LANDLORD			2007	119,994	3,076	39	3,076		9,741	13
14	SPECIAL EQUIPMENT- LANDLORD			2007	10,521	270	39	270		855	14
15	BLINDS & SHADES- LANDLORD			2007	6,170	158	39	158		500	15
16	CARPETS- LANDLORD			2007	6,133	157	39	157		497	16
17	SPECIAL CONSTRUCTION- LANDLORD			2007	14,852	381	39	381		1,207	17
18	ELECTRICAL- LANDLORD			2007	20,219	519	39	519		1,643	18
19	GENERAL REQUIREMENTS- LANDLORD			2007	36,552	937	39	937		2,967	19
20	BUILDERS OVERHEAD- LANDLORD			2007	8,143	209	39	209		662	20
21	BUILDERS PROFIT- LANDLORD			2007	40,719	1,044	39	1,044		3,306	21
22	ARCHITECT- LANDLORD			2007	22,320	572	39	572		1,811	22
23	INTEREST THRU PROJECT- LANDLORD			2007	3,698	95	39	95		301	23
24	CONSTRUCTION CHANGE- LANDLORD			2007	194	5	39	5		16	24
25	ARCHITECT- LANDLORD			2007	5,580	143	39	143		453	25
26											26
27	HOT WATER LINE			2008	4,330	104	39	104		234	27
28	COILER SYSTEM			2008	131,000	3,366	39	3,366		7,574	28
29											29
30	NEW PUMPS			2009	5,837	150	39	150		293	30
31	BOILER REMOVAL & REPLACE PUMP			2009	4,730	121	39	121		237	31
32	NEW BASEBOARD HEATING			2009	17,028	437	39	437		855	32
33	DRAINS & CONCRETE			2009	4,850	124	39	124		243	33
34	NEW HOT WATER COIL			2009	2,693	69	39	69		135	34
35	SPRINKLER SYSTEM			2009	5,980	153	39	153		301	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 & ID Number CAMBRIDGE NURSING REHAB CENTER # 0048959 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	NEW MOTORIZED VALVE BODY AND MOTOR	2010	$ 11,686	$ 287	39	$ 287	$	$ 287	37
38	NEW SEDIMENT/AIR REMOVING DEVICE	2010	7,535	185	39	185		185	38
39	NEW BLATER TANKS	2010	5,023	123	39	123		123	39
40	FIRE ALARM SYSTEM	2010	18,293	450	39	450		450	40
41	FIRE SCAPE	2010	2,500	62	39	62		62	41
42	DISH ROOM WALLS REPAIR	2010	3,800	93	39	93		93	42
43	CAULK WINDOWS	2010	2,600	64	39	64		64	43
44	DRYER VENTING	2010	3,733	92	39	92		92	44
45	HEATING SYSTEM	2010	21,014	516	39	516		516	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)		$ 3,105,726	$ 79,552		$ 79,552	$	$ 243,405	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: 01/01/2010 Ending: 12/31/2010

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	$ 139,647	$ 27,930	$ 13,965	$ (13,965)	10	$ 27,560	71
72	Current Year Purchases	37,857	37,857	1,893	(35,964)	10	1,893	72
73	Fully Depreciated Assets							73
74	RELATED PARTY		65,808	65,808				74
75	TOTALS	$ 177,504	$ 131,595	$ 81,666	$ (49,929)		$ 29,453	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	$ 13,552	$ (1)	3	$ 40,658	76
77	FACILITY	2010 FORD	2010	50,811	50,811	10,163	(40,648)	5	10,163	77
78										78
79										79
80	TOTALS			$ 91,469	$ 64,364	$ 23,715	$ (40,649)		$ 50,821	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)	$	3,649,949	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	275,511	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	184,933	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	(90,578)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	323,679	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.

Facility Name & ID Number CAMBRIDGE NURSING REHAB CENTER # 0048959 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

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

	Fiscal Year Ending	Annual Rent
12.		$
13.		$
14.		$

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: $ 49,341 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	FACILITY	2005 FORD E350	398.37	1,576	18
19					19
20					20
21	TOTAL		$ 398.37	$ 1,576	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 CENTER # 0048959 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number CAMBRIDGE NURSING REHAB CENTER # 0048959 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 201,406	$		$ 201,406	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			61,651			61,651	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs							4
5	Physician Care	39-3	visits			157,043			157,043	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				221,479		221,479	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$ 420,100	$ 221,479		$ 641,579	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.

STATE OF ILLINOIS

Facility Name & ID Number CAMBRIDGE NURSING REHAB CENTER # 0048959 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2010 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,377,451	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (180,500))	365,272		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due From Landlord	518,926		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,261,649	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	252,632		15
16	Equipment, at Historical Cost	268,972		16
17	Accumulated Depreciation (book methods)	(182,680)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 338,924	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,600,573	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 266,403	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	91,802		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	227,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Skokie 2	2,006,257		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,591,462	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,591,462	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 9,111	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,600,573	$	48

***(See instructions.)**

Facility Name & ID Number CAMBRIDGE NURSING REHAB CENTER # 0048959 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	319,111	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	(310,000)	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)**	$ 9,111	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 9,111	24 *

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

Facility Name & ID Number CAMBRIDGE NURSING REHAB CENTER # 0048959 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,772,256	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,772,256	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	151,906	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 151,906	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	136	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 136	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING COMMISSIONS	1,096	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,096	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,925,394	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,112,383	31
32	Health Care	2,309,267	32
33	General Administration	1,159,647	33
	B. Capital Expense		
34	Ownership	1,321,539	34
	C. Ancillary Expense		
35	Special Cost Centers	641,579	35
36	Provider Participation Fee	61,868	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,606,283	40
41	**Income before Income Taxes (line 30 minus line 40)****	319,111	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 319,111	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

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

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

Facility Name & ID Number CAMBRIDGE NURSING REHAB CENTER # 0048959 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,904	2,117	$ 85,080	$ 40.19	1
2	Assistant Director of Nursing	1,960	2,117	78,956	37.30	2
3	Registered Nurses	24,359	26,441	759,107	28.71	3
4	Licensed Practical Nurses	6,348	6,981	174,427	24.99	4
5	CNAs & Orderlies	54,742	58,912	644,175	10.93	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,936	2,080	40,148	19.30	9
10	Activity Assistants	5,810	6,356	63,083	9.92	10
11	Social Service Workers	5,832	6,400	120,761	18.87	11
12	Dietician					12
13	Food Service Supervisor	1,984	2,080	40,298	19.37	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,847	26,318	273,392	10.39	15
16	Dishwashers					16
17	Maintenance Workers	1,948	2,080	32,430	15.59	17
18	Housekeepers	8,774	9,564	106,923	11.18	18
19	Laundry	16,355	18,091	198,922	11.00	19
20	Administrator	56	56	2,176	38.86	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,149	2,410	45,959	19.07	23
24	Clerical	3,666	4,161	82,159	19.75	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)	1,726	1,858	24,231	13.04	30
31	Medical Records	2,149	2,410	46,040	19.10	31
32	Other Health C: MDS	3,214	3,459	116,645	33.72	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	166,759	183,891	$ 2,934,912 *	$ 15.96	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	240	$ 11,267	1-3	35
36	Medical Director	52	13,000	9-3	36
37	Medical Records Consultant	96	4,416	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	40	1,800	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	45	2,640	11-3	44
45	Social Service Consultant	81	4,735	12-3	45
46	Other(specify) PHYSICIANS	48	12,000	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	602	$ 49,858		49

C. CONTRACT NURSES

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

Facility Name & ID Number CAMBRIDGE NURSING REHAB CENTER # 0048959 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
EUGCNE BGRGER	ADMINISTRATOR	0	$ 2,176
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 2,176

B. Administrative - Other

Description	Amount
MARK APPEL MANAGEMENT FEES	$ 312,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 312,000

C. Professional Services

Vendor/Payee	Type	Amount
SEE SCHEDULE ATTACHED		81,618
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 81,618

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 0
Unemployment Compensation Insurance	16,095
FICA Taxes	221,716
Employee Health Insurance	205,867
Employee Meals	25,550
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	2,850
EMPLOYEE PHYSICAL EXAMS	2,422
PENSION/PROFIT SHARING PLANS	35,169
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 509,669

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	4,621
Health Care Worker Background Check	850
(Indicate # of checks performed 85)	
Patient Background Checks 18	520
TRUST/FRANCHISE/CONTRIB/ETC	4,342
MARKETING/ADV/PROMO	32,471
LICENSES/DUES/SUBSCRIPTIONS	17,713
MGMT CO ALLOC	
TRUST/FRANCHISE/CONTRIB/ETC	(4,342)
Less: Public Relations Expense	(0)
Non-allowable advertising	(28,175)
Yellow page advertising	(4,296)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 27,684

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number CAMBRIDGE NURSING REHAB CENTER # 0048959 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6							N/A						
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number CAMBRIDGE NURSING REHAB CENTER # 0048959 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 $9,984**

(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. $ **0** 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. $ **25,550** 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.