FOR BHF USE

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2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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

I. IDPH License ID Number: 0048959

Facility Name: CAMBRIDGE NURSING REHAB CENTER

Address: 9615 N. KNOX (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: 11/01/07

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: SANFORD BOKOR **Telephone Number:** (847) 675-3585
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2017 to 12/31/2017 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) SANFORD BOKOR, PRESIDENT
(Firm Name & Address) KBKB, LTD, 8140 RIVER DRIVE, MORTON GROVE, IL 60053
(Telephone) (847) 675-3585 Fax # (847) 675-5777

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

Facility Name & ID Number CAMBRIDGE NURSING REHAB CENTER # 0048959 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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			1,868	1,868	8
9	SNF/PED					9
10	ICF	24,683	3,497	3,112	31,292	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,683	3,497	4,980	33,160	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.40%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve 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 11/1/07

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified _____ and days of care provided 1,868

Medicare Intermediary _____

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number CAMBRIDGE NURSING REHAB CENTER # 0048959 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	357,559	28,389	12,825	398,773		398,773		398,773			1
2	Food Purchase		189,186		189,186	(24,236)	164,950	(182)	164,768			2
3	Housekeeping	192,120	14,209		206,329		206,329		206,329			3
4	Laundry	95,402	18,324	1,000	114,726		114,726		114,726			4
5	Heat and Other Utilities			110,440	110,440		110,440		110,440			5
6	Maintenance	32,563	21,567	100,845	154,975		154,975		154,975			6
7	Other (specify):*			12,670	12,670		12,670		12,670			7
8	**TOTAL General Services**	677,644	271,675	237,780	1,187,099	(24,236)	1,162,863	(182)	1,162,681			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,954,494	74,839	44,926	2,074,259		2,074,259		2,074,259			10
10a	Therapy											10a
11	Activities	77,011	18,323	2,741	98,075		98,075		98,075			11
12	Social Services	71,614		11,594	83,208		83,208		83,208			12
13	CNA Training											13
14	Program Transportation			190	190		190		190			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,103,119	93,162	71,451	2,267,732		2,267,732		2,267,732			16
	C. General Administration											
17	Administrative	44,100		120,000	164,100		164,100		164,100			17
18	Directors Fees											18
19	Professional Services			78,741	78,741		78,741		78,741			19
20	Dues, Fees, Subscriptions & Promotions			68,304	68,304		68,304	(24,401)	43,903			20
21	Clerical & General Office Expenses	227,576	7,561	9,239	244,376		244,376	(972)	243,404			21
22	Employee Benefits & Payroll Taxes			561,544	561,544	24,236	585,780		585,780			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			8,056	8,056		8,056		8,056			25
26	Insurance-Prop.Liab.Malpractice			147,492	147,492		147,492	15,576	163,068			26
27	Other (specify):*											27
28	**TOTAL General Administration**	271,676	7,561	993,376	1,272,613	24,236	1,296,849	(9,797)	1,287,052			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,052,439	372,398	1,302,607	4,727,444		4,727,444	(9,979)	4,717,465			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: 01/01/2017** **Ending: 12/31/2017**

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	12,825	
	REPAIRS & MAINTENANCE		0	
				12,825
3	**HOUSEKEEPING**			
			0	
				0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
	OUTSIDE LABOR		1,000	1,000
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		21,303	
	ELECTRICITY		59,044	
	WATER		19,797	
	CABLE TV - LOBBY		10,296	
				110,440
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		7,024	
	PAINTING & DECORATING		13,360	
	BUILDING REPAIRS		16,891	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		31,399	
	ELEVATOR MAINTENANCE & REPAIR		16,455	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		3,725	
	FIRE SERVICE		4,995	
	CONTRACTED BUILDING MAINT.		6,996	
				100,845
7	**OTHER**			
	SCAVENGER		12,520	
	SECURITY SERVICE		150	
				12,670
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	12,000	12,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		5,720	
	PURCHASED SERVICES		17,256	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	4,400	
	PHARMACY CONSULTANT	XVIII B 39-2	5,732	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	10,500	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
	PROGRAM CONSULTANT		1,048	
	DENTAL		270	44,926
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTANT	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,741	
				2,741
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	11,594	
				11,594
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII		0

Facility Name & ID Number CAMBRIDGE NURSING REHAB CENTER **#0048959** **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		190	
				190
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	120,000	120,000
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	21,103	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	57,638	
				78,741
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	17,653	
	EMPLOYEE RECRUITMENT/WANT ADS	XIX F	617	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	37,673	
	LICENSES & PERMITS	XIX F	5,613	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	6,748	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHECKS	XIX F	0	
	PATIENT BACKGROUND CHECKS	XIX F	0	
				68,304
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		972	
	EQUIPMENT REPAIR & MAINTENANCE		0	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		8,267	
	MESSENGER SERVICE		0	
				9,239

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	230,354	
	UNEMPLOYMENT COMPENSATION	XIX D	13,945	
	WORKERS COMPENSATION INSURANC	XIX D	42,542	
	HOSPITALIZATION INSURANCE	XIX D	237,838	
	EMPLOYEE BENEFITS - OTHER	XIX D	4,090	
	EMPLOYEE PHYSICAL EXAMS	XIX D	2,765	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	30,010	
				561,544
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	
				0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		8,056	
				8,056
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		147,492	
				147,492
27	**OTHER**			
	BAD DEBTS	VI 24	0	
				0

GRAND TOTAL COLUMN 3 OTHER **1,302,607**

CAMBRIDGE NURSING REHAB CENTER
SCHEDULES
12/31/2017

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

TOTAL FOOD PURCHASE	189,186
LESS SALES TAX	(182)
NET FOOD	189,004
TOTAL PATIENT CENSUS	33,160
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	99,480
ADD # EMPLOYEE MEALS/DAY	40
TIMES # DAYS	365
TOTAL EMPLOYEE MEALS	14,600
PATIENT MEALS	99,480
ADD EMPLOYEE MEALS	14,600
TOTAL MEALS/YEAR	114,080
NET FOOD	189,004
DIVIDE TOTAL MEALS/YEAR	114,080
COST PER MEAL	1.66
TIMES EMPLOYEE MEALS	14,600
EMPLOYEE MEAL RECLASSIFICATION	**24,236**

Facility Name & ID Number CAMBRIDGE NURSING REHAB CENTER #0048959 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	Capital Expense	Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			14,676	14,676		14,676	108,093	122,769			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							155,331	155,331			32
33	Real Estate Taxes			295,110	295,110		295,110		295,110			33
34	Rent-Facility & Grounds			640,065	640,065		640,065	(640,065)				34
35	Rent-Equipment & Vehicles			28,419	28,419		28,419		28,419			35
36	Other (specify):* STORAGE							35,433	35,433			36
37	TOTAL Ownership			978,270	978,270		978,270	(341,208)	637,062			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		127,589	305,228	432,817		432,817		432,817			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			252,312	252,312		252,312		252,312			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		127,589	557,540	685,129		685,129		685,129			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,052,439	499,987	2,838,417	6,390,843		6,390,843	(351,187)	6,039,656			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: 01/01/2017 Ending: 12/31/2017

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	34,937	30		9
10	Interest and Other Investment Income	(4,951)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(182)	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	(17,653)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(6,748)	20		28
29	Other-Attach Schedule SEE PG 5A	(972)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 4,431		$	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)	(355,618)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (355,618)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (351,187)		37

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

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

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

STATE OF ILLINOIS

CAMBRIDGE NURSING REHAB CENTER

ID# 0048959

Report Period Beginning: 01/01/2017

Ending: 12/31/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	BANK CHARGES	$ (972)	21	1
2	IL COUNCIL LONG TERM CARE COPE		20	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(972)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CAMBRIDGE NURSING REHAB CENTER **#** 0048959 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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	(182)	0	0	0	0	0	0	0	0	0	0	(182)	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**	(182)	0	0	0	0	0	0	0	0	0	0	(182)	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	(24,401)	0	0	0	0	0	0	0	0	0	0	(24,401)	20
21	Clerical & General Office Expenses	(972)	0	0	0	0	0	0	0	0	0	0	(972)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	15,576	0	0	0	0	0	0	0	0	0	15,576	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(25,373)	15,576	0	0	0	0	0	0	0	0	0	(9,797)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(25,555)	15,576	0	0	0	0	0	0	0	0	0	(9,979)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number CAMBRIDGE NURSING REHAB CENTER **#** 0048959 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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)	
	D. Ownership													
30	Depreciation	34,937	73,156	0	0	0	0	0	0	0	0	0	108,093	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,951)	160,282	0	0	0	0	0	0	0	0	0	155,331	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(640,065)	0	0	0	0	0	0	0	0	0	(640,065)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	35,433	0	0	0	0	0	0	0	0	0	35,433	36
37	**TOTAL Ownership**	29,986	(371,194)	0	0	0	0	0	0	0	0	0	(341,208)	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)**	4,431	(355,618)	0	0	0	0	0	0	0	0	0	(351,187)	45

Facility Name & ID Number CAMBRIDGE NURSING REHAB CENTER # 0048959 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

VII. RELATED PARTIES

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

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

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. [X] 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	$ 640,065	SKOKIE CAMBRIDGE REALTY LLC		$	$ (640,065)	1
2	V	26	INSURANCE				15,576	15,576	2
3	V	30	DEPRECIATION				73,156	73,156	3
4	V	32	INTEREST				154,989	154,989	4
5	V	36	MIP INSURANCE				35,433	35,433	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			$ 640,065			$ 284,447	$ * (355,618)	14

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

Facility Name & ID Number CAMBRIDGE NURSING REHAB CENTER # 0048959 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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 CENTEI # 0048959 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MARK APPEL	CFO	FINANCIAL	50.00				mngmt fee	$ 120,000	17-3	1
2											2
3	JOAN WILLEY	CFO	ADMINISTRATIV	50.00	120,000						3
4											4
5					SKOKIE MEADOWS NURSING CENTER #2						5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 120,000		13

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

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

Facility Name & ID Number CAMBRIDGE NURSING REHAB CENTER # 0048959 Report Period Beginning: 01/01/2017 Ending: 2/31/2017

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 [X]

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 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						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CAMBRIDGE NURSING REHAB CENTER # 0048959 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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			MORTGAGE		12/21/12		6,372,831			154,989	2
3	LOAN COST			AMORTIZE OVER LIFE OF LOAN			79,398	52,933			5,293	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 79,398	$ 6,425,764			$ 160,282	9
	B. Non-Facility Related*											
10	IRS,IDR,ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 79,398	$ 6,425,764			$ 160,282	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 35,433 **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:** 01/01/2017 **Ending:** 12/31/2017

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	295,000	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.)	$	290,110	2
3. Under or (over) accrual (line 2 minus line 1).	$	(4,890)	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)	$	300,000	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.	$	295,110	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	254,291	8
	2013	282,056	9
	2014	282,678	10
	2015	289,430	11
	2016	290,110	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~103% OF THE PRIOR YEAR REAL ESTATE TAX BILL - THE PAYMENT ON LINE 2 APPLIES TO THE 2016 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 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 SANFORD BOKOR

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

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-10-304-007-0000	NURSING HOME	$ 48,347.01	$ 48,347.01
2.	10-10-304-008-0000	NURSING HOME	$ 48,352.65	$ 48,352.65
3.	10-10-304-009-0000	NURSING HOME	$ 48,352.65	$ 48,352.65
4.	10-10-304-010-0000	NURSING HOME	$ 48,352.65	$ 48,352.65
5.	10-10-304-011-0000	NURSING HOME	$ 48,352.65	$ 48,352.65
6.	10-10-304-012-0000	NURSING HOME	$ 48,352.65	$ 48,352.65
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 290,110.26	$ 290,110.26

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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: 01/01/2017 Ending: 12/31/2017

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			2007	$ 275,250	1
2					2
3	TOTALS			$ 275,250	3

Facility Name & ID Number CAMBRIDGE NURSING REHAB CENTER # 0048959 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	111			2007	$ 2,365,250	$ 60,647	39	$ 60,647	$	$ 555,931	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	CARPENTRY-LANDLORD			2007	83,324	2,137	39	2,137		21,726	9
10	WINDOWS- LANDLORD			2007	24,779	635	39	635		6,456	10
11	DRYWALL- LANDLORD			2007	3,685	95	39	95		966	11
12	FLOORING- LANDLORD			2007	80,961	2,076	39	2,076		21,106	12
13	PAINTING & DECORATING- LANDLORD			2007	119,994	3,076	39	3,076		31,273	13
14	SPECIAL EQUIPMENT- LANDLORD			2007	10,521	270	39	270		2,745	14
15	BLINDS & SHADES- LANDLORD			2007	6,170	158	39	158		1,606	15
16	CARPETS- LANDLORD			2007	6,133	157	39	157		1,596	16
17	SPECIAL CONSTRUCTION- LANDLORD			2007	14,852	381	39	381		3,874	17
18	ELECTRICAL- LANDLORD			2007	20,219	519	39	519		5,276	18
19	GENERAL REQUIREMENTS- LANDLORD			2007	36,552	937	39	937		9,526	19
20	BUILDERS OVERHEAD- LANDLORD			2007	8,143	209	39	209		2,125	20
21	BUILDERS PROFIT- LANDLORD			2007	40,719	1,044	39	1,044		10,614	21
22	ARCHITECT- LANDLORD			2007	22,320	572	39	572		5,815	22
23	INTEREST THRU PROJECT- LANDLORD			2007	3,698	95	39	95		966	23
24	CONSTRUCTION CHANGE- LANDLORD			2007	194	5	39	5		51	24
25	ARCHITECT- LANDLORD			2007	5,580	143	39	143		1,454	25
26											26
27	HOT WATER LINE			2008	4,330	104	39	104		962	27
28	BOILER SYSTEM			2008	131,000	3,366	39	3,366		31,136	28
29											29
30	NEW PUMPS			2009	5,837	150	39	150		1,343	30
31	BOILER REMOVAL & REPLACE PUMP			2009	4,730	121	39	121		1,084	31
32	NEW BASEBOARD HEATING			2009	17,028	437	39	437		3,914	32
33	DRAINS & CONCRETE			2009	4,850	124	39	124		1,111	33
34	NEW HOT WATER COIL			2009	2,693	69	39	69		618	34
35	SPRINKLER SYSTEM			2009	5,980	153	39	153		1,372	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: 01/01/2017 Ending: 12/31/2017

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	$ 299	39	$ 299	$	$ 2,380	37
38	NEW SEDIMENT/AIR REMOVING DEVICE	2010	7,535	193	39	193		1,536	38
39	NEW BLATER TANKS	2010	5,023	129	39	129		1,026	39
40	FIRE ALARM SYSTEM	2010	18,293	469	39	469		3,733	40
41	FIRE SCAPE	2010	2,500	64	39	64		510	41
42	DISH ROOM WALLS REPAIR	2010	3,800	97	39	97		772	42
43	CAULK WINDOWS	2010	2,600	67	39	67		533	43
44	DRYER VENTING	2010	3,733	96	39	96		764	44
45	HEATING SYSTEM	2010	21,014	539	39	539		4,289	45
46									46
47	ADMINI. ASS. SUSPENDED CEILING	2011	3,188	82	39	82		574	47
48	NURSE OFFICE SUSPENDED CEILING	2011	2,929	75	39	75		525	48
49	REPAIR KITCHEN WALL	2011	3,500	90	39	90		630	49
50	remove & replaced drywall, tiling, then repaint staff bathroom	2011	3,973	102	39	102		714	50
51	remove & replaced drywall, tiling, then repaint public bathroom	2011	4,221	108	39	108		756	51
52	KITCHEN DOORS AND WALL REPLACEMENT	2011	8,934	229	39	229		1,603	52
53	WALLPAPER	2011	1,800	46	39	46		322	53
54									54
55	replace exterior kitchen door and replace wall behind stove	2012	5,228	134	39	134		799	55
56	remodeling of doorway and doors to the kitchen	2012	7,975	205	39	205		1,221	56
57									57
58	Remodeling of Dish Room and Part of Kitchen Walls	2013	11,050	284	39	284		1,407	58
59	removed 30lf of dish room wall and built new wall with metal studs								59
60	and mold resistant 5/8 drywall.installed 300 sq ft. of ceramictiles on								60
61	the new wall. Installed 30lf base board. Removed suspended ceiling								61
62	and replaced with new fire rated grid ceiling tiles,replaced 1x4 light								62
63	fixtures with recess lights.								63
64	Dining Room Remodeling. Removed old wall and installed new	2013	13,540	347	39	347		1,721	64
65	drywall.went over the walls with new 5/8 fire rated drywalls,patched								65
66	sanded and primed for new finish. Replaced existing rotton base								66
67	cabinets,replaced with new top and botton cherry cabinets, crown								67
68	molding,and granite counter top. Installed ceramic baseboard around								68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,172,064	$ 81,335		$ 81,335	$	$ 750,461	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: 01/01/2017 Ending: 12/31/2017

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	
1	Totals from Page 12A, Carried Forward		$ 3,172,064	$ 81,335		$ 81,335	$	$ 750,461	1
2	Flooring In Therapy Room	2013	11,986	307	39	307		1,523	2
3	Tankless Water Heater	2013	25,000	641	39	641		3,178	3
4	RE-PIPING OF 3 BOILERS IN BOILER ROOM	2013	26,913	690	39	690		3,421	4
5	MODERNIZATION OF THE HYDRAULIC ELEVATORS	2014	79,550	2,040	39	2,040		8,074	5
6	REMOVED APPROXIMATELY 2,450 FT OF PAVERS ON THE WALKWAY AND PATIO SIDE. REPLACED BAD GRAVEL WITH NEW SCREENING								6
7	LIMESTONE FOR PROPER BASE FOR NEW PAVERS. INSTALLE NEW DRAIN SYSTEM FOR BETTER STORM WATER DRAINAGE. USED								7
8	POLYMERIC SAND FOR PAVERS JOINT	2014	36,000	923	39	923		3,654	8
9	CURB AROUND THE WALKWAY, BRICK WALLS, AND 2 PILLARS FOR FLOWERPOTS FOR $2,000. PATIO SIDE INCLUDES NEW CURB,								9
10	AND LIGHT POST WITH THE LIGHT FOR $1,500. 2 TUSCANY FLOWER								10
11	VASES FOR $450	2014	3,950	101	39	101		400	11
12	REQUIRED BY ASHRAE	2016	70,000	1,795	39	1,795		3,515	12
13	DISCONNECTED AND REMOVED THE EXISTING HOT WATER CIRCULATION PUMP; FURNISHED AND INSTALLED A NEW LEAD FREE								13
14	HOT WATER BRONZE RE-CIRCULATION PUMP; FURNISHED AND INSTALLED A NEW 1" BALL VALVE, 1" CHECK VALVE, AND 5'								14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,425,463	$ 87,832		$ 87,832	$	$ 774,226	34

**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: 01/01/2017 Ending: 12/31/2017

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	$ 349,361	$	$ 34,937	$ 34,937		$ 213,690	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 349,361	$	$ 34,937	$ 34,937		$ 213,690	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	ADMINISTRATOR	2008 LEXUS ES 350	2008	$ 40,658	$	$	$		$ 40,658	76
77	FACILITY	2010 FORD	2010	50,811					50,811	77
78	ADMINISTRATOR	2011 HUNDAI	2011	35,517					35,517	78
79										79
80	TOTALS			$ 126,986	$	$	$		$ 126,986	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)	$ 4,177,060	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 87,832	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 122,769	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 34,937	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,114,902	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: 01/01/2017 Ending: 12/31/2017

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5					640,065			5
6								6
7	TOTAL				$ 640,065 **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 28,419 Description:
    (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 CENTER # 0048959 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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: 01/01/2017 Ending: 12/31/2017

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 138,134	$		$ 138,134	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			33,772			33,772	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			133,322			133,322	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				127,589		127,589	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	MED.SUPPLIES/LAB/RADIOLOGY Other (specify):	39-2								13
14	TOTAL			$		$ 305,228	$ 127,589		$ 432,817	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:** 01/01/2017 **Ending:** 12/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2017 **(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	$ 1,159,330	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (82,913))	1,215,666		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):	3,985,312		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 6,360,308	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	572,369		15
16	Equipment, at Historical Cost	476,347		16
17	Accumulated Depreciation (book methods)	(568,433)		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)**	$ 480,283	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,840,591	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 183,556	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	165,755		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	300,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	SKOKIE 1 & 2 ELIMINATION	3,476,220		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,125,531	$	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)**	$ 4,125,531	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,715,060	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,840,591	$	48

***(See instructions.)**

Facility Name & ID Number CAMBRIDGE NURSING REHAB CENTER # 0048959 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,516,278	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,516,278	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	874,782	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	(676,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) OUT OF PERIOD EXPENSES		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 198,782	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,715,060	24 *

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

Facility Name & ID Number CAMBRIDGE NURSING REHAB CENTER # 0048959 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,048,329	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,048,329	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	198,291	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 198,291	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	1,444	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)**	$ 1,444	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,951	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,951	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,253,015	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,187,099	31
32	Health Care	2,267,732	32
33	General Administration	1,272,613	33
	B. Capital Expense		
34	Ownership	978,270	34
	C. Ancillary Expense		
35	Special Cost Centers	432,817	35
36	Provider Participation Fee	252,312	36
	D. Other Expenses (specify):		
37	PRIOR YEARS MEDICARE ADJ	(12,610)	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,378,233	40
41	**Income before Income Taxes (line 30 minus line 40)****	874,782	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 874,782	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,606,771	44
45	Private Pay - Net Inpatient Revenue	688,349	45
46	Medicare - Net Inpatient Revenue	1,113,257	46
47	Other-(specify) VETERAN	639,952	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,048,329	49

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

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

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

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

Facility Name & ID Number CAMBRIDGE NURSING REHAB CENTER # 0048959 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	2,043	2,140	$ 89,447	$ 41.80	1
2	Assistant Director of Nursing	1,679	1,895	64,560	34.07	2
3	Registered Nurses	21,445	23,429	709,145	30.27	3
4	Licensed Practical Nurses	6,118	6,613	169,537	25.64	4
5	CNAs & Orderlies	59,350	62,940	814,985	12.95	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,936	2,080	33,758	16.23	9
10	Activity Assistants	3,753	3,836	43,253	11.28	10
11	Social Service Workers	3,456	3,768	71,614	19.01	11
12	Dietician					12
13	Food Service Supervisor	1,960	2,080	42,894	20.62	13
14	Head Cook					14
15	Cook Helpers/Assistants	24,815	27,056	314,665	11.63	15
16	Dishwashers					16
17	Maintenance Workers	1,958	2,086	32,563	15.61	17
18	Housekeepers	15,048	15,808	192,120	12.15	18
19	Laundry	6,268	6,892	95,402	13.84	19
20	Administrator	1,936	2,080	44,100	21.20	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,921	2,226	45,040	20.23	23
24	Clerical	6,183	6,678	120,719	18.08	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,865	2,185	25,552	11.69	31
32	Other Health C: MDS	1,880	2,080	81,268	39.07	32
33	Other(specify) CARE PLANS	2,043	2,147	61,817	28.79	33
34	TOTAL (lines 1 - 33)	165,657	178,019	$ 3,052,439 *	$ 17.15	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	229	$ 12,825	1-3	35
36	Medical Director	48	12,000	9-3	36
37	Medical Records Consultant	73	4,400	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	143	5,732	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	44	2,741	11-3	44
45	Social Service Consultant	184	11,594	12-3	45
46	Other(specify) PHYSICIANS	96	10,500	10-3	46
47	PROGRAM CONSULTANT		1,048	10-3	47
48	DENTAL		270	10-3	48
49	TOTAL (lines 35 - 48)	817	$ 61,110		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number CAMBRIDGE NURSING REHAB CENTER # 0048959 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
EUGCNE BGRGER	ADMINISTRATOR		$ 44,100
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 44,100

B. Administrative - Other

Description	Amount
MARK APPEL MANAGEMENT FEES	$ 120,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 120,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		78,741
SEE LEGAL SCHEDULE ATTACHED		
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 78,741

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 42,542
Unemployment Compensation Insurance		13,945
FICA Taxes		230,354
Employee Health Insurance		237,838
Employee Meals		24,236
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		4,090
EMPLOYEE PHYSICAL EXAMS		2,765
PENSION/PROFIT SHARING PLANS		30,010
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 585,780

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	$
Advertising: Employee Recruitment	617
Health Care Worker Background Check	0
(Indicate # of checks performed)	
Patient Background Checks	0
TRUST/FRANCHISE/CONTRIB/ETC	0
MARKETING/ADV/PROMO	24,401
LICENSES/DUES/SUBSCRIPTIONS	43,286
MGMT CO ALLOC	
TRUST/FRANCHISE/CONTRIB/ETC	0
Less: Public Relations Expense	(0)
Non-allowable advertising	(17,653)
Yellow page advertising	(6,748)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 43,903

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.

CAMBRIDGE NURSING REHAB CENTER
Legal Fee Schedule

INVOICE DATE	FIRM NAME	AMOUNT	DESCRIPTION OF SERVICES
1/31/2017	PAUL W. PLOTNICK	400.00	GUARDIAN
3/14/2017	NEAL, GERBER & EISENBERG	637.50	MAYRA ORTIZ IDHR CHARGE
4/21/2017	NEAL, GERBER & EISENBERG	801.00	MAYRA ORTIZ IDHR CHARGE
		1,838.50	

Facility Name & ID Number CAMBRIDGE NURSING REHAB CENTER # 0048959 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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 $16,114**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **252,312**
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. $ **24,236** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name:

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **YES**
Attach invoices and a summary of services for all architect and appraisal fees.